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Opportunities to Enhance HCBS for Older Adults and Individuals Providing Care

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EXECUTIVE SUMMARY

As a nationally recognized long-term support services (LTSS) and home- and community-based services (HCBS) leader for more than two decades, Minnesota has regularly reviewed the programs and services it offers older adults to identify gaps and introduce innovations. These iterative improvements have taken on growing importance. In 2010−2030, the percentage of Minnesotans ages 65 and older is predicted to double to 20 percent, or one in five state residents. One strategy that the Minnesota Department of Human Services (DHS) has developed to help the older population age in place and avoid institutionalization is to bolster its natural support systems—informal caregivers, such as family members, friends, neighbors—by enhancing the accessibility and use of the state's caregiver support services.

To achieve this goal, DHS partnered in September 2022 with Health Management Associates (HMA), a national healthcare research and consulting firm, to study Minnesota's HCBS trends; changes in its demographics, including the experiences of diverse communities; and successful local and national HCBS models to inform future efforts to improve access to supports for older Minnesotans and their informal caregivers. DHS and HMA agreed to focus the study on a limited set of services—including primary supports (e.g., caregiver education/training, coaching/counseling, and respite) and secondary supports (e.g., adult day services, personal care, and individual community living supports)—funded through Minnesota's Alternative Care (AC) program, its Elderly Waiver (EW), and Older Americans Act (OAA) HCBS programs.

After analyzing available state data, reviewing programmatic policies and procedures, and conducting key informant interviews with Minnesota LTSS leaders, HMA found philosophical and operational differences among the AC, EW, and OAA approaches to supporting older adults' informal caregivers that detract from the accessibility, use, and effectiveness of the state's caregiver support services. These variances include:

- Different definitions of "caregiver" and "caregiver support services," as well as inconsistencies in the types of supports available.
- Different points of focus. The priority of AC case managers and EW care coordinators is to address the needs of the older adult program participant. OAA caregiver consultants are dedicated specifically to supporting caregivers.

- Different triggers for caregiver assessment. AC case managers and EW care coordinators screen and assess all participants' caregivers, predominantly the ones who are present during the participant's assessment. OAA caregiver consultants only assess caregivers whom they encounter.
- Varying caregiver screening tools and methodologies for gathering and storing data, as well as specific data points stored. Also, different Minnesota HCBS provider networks and data sources to identify caregiver support services providers.

Variation in use of caregiver support services are apparent among the three programs. Only OAA consistently supports large numbers of caregivers. Moreover, the programs varied in terms of the demographic compositions of the older adults and caregivers served.

HMA also found that AC, EW, and OAA staff were unaware of each other's programs, with opportunities to work more collaboratively identified. In short, these three systems at times function in silos, despite the strong likelihood they serve the same older Minnesotans and their caregivers at various points in time. To better align these programs—and thereby increase access to caregiver support services and coordinate efforts—HMA has three broad recommendations with specific strategies and action steps detailed further in this report. They include:

HCBS Network Navigation and Service Alignment: DHS should improve the consistency and availability of HCBS provider network information for caregiver navigators and Minnesotans by aligning the MHCP provider directory, managed care organization (MCO) provider enrollment compact disc (PECD) file, and MinnesotaHelp.info platform and prioritizing relevant data elements. HMA recommends that DHS pursue alignment among the three programs regarding working definitions and a universal referral form to create greater cross-program referrals and access to needed services. Educational forums should be created to support sharing of best practices among AC case managers, EW care coordinators, and OAA caregiver consultants.

Enhanced Caregiver Support through Strengthened Identification of Needs and Caregiver Support Planning: DHS should require AC case managers and EW care coordinators to refer all identified caregivers to a caregiver consultant for evidence-based assessment and individualized care planning. To raise the level of caregiving expertise within the HCBS system, all AC case managers, EW care coordinators, and OAA caregiver consultants

should receive more training in the caregiver needs. That training should include model curricula reflecting emerging national standards and participation in a caregiver navigators best practices workgroup.

Statewide Caregiver Resource Platform and Measurement Strategy: DHS should make available a caregiver resource platform, containing educational/training tools for caregivers, available for Minnesota caregivers identified in OAA, AC, and EW programs, without the need for permission to access the platform. To better serve Minnesota's diverse communities, caregiver educational and training materials should be translated into priority languages. The annual caregiver survey that OAA uses should be expanded into the EW and AC programs to measure caregiver satisfaction with support services. The survey tool should be updated to include questions related to specific outcomes (e.g., participant emergency department visits, hospital admissions, and skilled nursing facility placements) to help DHS determine its return on investment in caregiver support services.

In addition, HMA identified several areas for DHS to consider for future innovations, including offering caregiver support services to informal caregivers of participants who are younger than 60 years old; launching a renewed public campaign to increase caregiver awareness and engagement; increasing the number of Minnesota caregiver consultants; leveraging dormant HCBS providers; and recruiting volunteers and peers to increase caregiver engagement and support.

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INTRODUCTION

Minnesota is a recognized national leader and innovator in home- and community-based services (HCBS), with a history of investment in research to clarify needs and inform solutions. These efforts have led to the establishment of powerful programs with meaningful results. In fact, Minnesota has ranked among the top two states on the AARP's Long-Term Services and Supports (LTSS) Scorecard for more than a decade. A state only achieves this status if it engages in continuous performance assessment and continually monitors national trends for opportunities to improve.

Minnesota has a record of rebalancing the long-term care system, which has resulted in less reliance on institutional care and increased funding for HCBS. Moreover, Minnesota has a history of investing in research on the barriers and challenges Minnesotans' experience in accessing HCBS. Supporting caregivers of all ages is a key theme of the Aging 2030 initiative, which is intended to make family caregiving more accessible to increasingly diverse lifestyles.

In 1997, the Minnesota Department of Human Services (DHS) launched the Aging Initiative Project, the first of its kind to analyze demographic changes and state trends. From the late 1990s through the early 2000s, Minnesota made significant investments in HCBS service capacity development. DHS followed up on the Aging Initiative Project with the Transform 2010 report to identify the effects of the state's aging population and to transform policies, infrastructures, and services so that the state can survive and thrive during the demographic shift of an aging population.

This work focused on communities by targeting organizations through competitive processes to obtain seed money that could be used to transform local systems, services, and policies across the state. As a result, Medicaid spending slowed as older Minnesotans were able to avoid or delay the need for assisted living or institutionalization.

The state legislature had the vision and foresight to establish Community Service, Community Services Development, Aging CORE, Caregiver Respite (also known as Live Well at Home Grants), and the ElderCare Development Partnership Grants. At the time, more than 15 years ago, concerns about a workforce shortage, financial solvency, the cost of HCBS, and the need to support caregivers were prevalent topics of concern in healthcare. DHS has tirelessly worked to address these themes, resulting in Reform 2020, an 1115 demonstration action plan that has evolved and been extended to Medicaid and other Minnesota programs and systems as they prepared to face the challenge of changing demographics while leveraging new program flexibilities.

Most recently, Minnesota has been working on the Aging 2030 initiative, which builds on all the research and action that has occurred in HCBS to meet the needs of Minnesotans throughout the past 25 years.

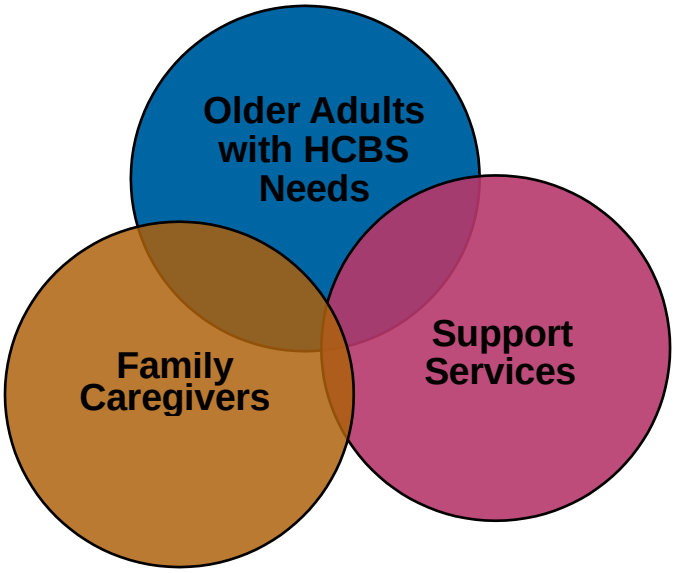
Now is the time for DHS to review the work that has been accomplished, understand the changing populations who need these services, explore workforce dynamics, assess current care and other utilization trends, and reflect on where to go next. In furtherance of this goal, Health Management Associates (HMA) has analyzed access to respite services; supports for family, friends, and neighbor caregivers; and opportunities to strengthen the HCBS system for older adults and their caregivers.

AARP estimated that 530,000 Minnesotans were serving as family caregivers in 2021—more than one in 11 people, representing 500 million hours of care and $10 billion in economic value.[1] Among states, Minnesota ranks 26th in estimated caregivers and 20th in the economic value those dedicated individuals provide.

Myriad factors can affect caregiving interventions, including the characteristics of the care recipient, the caregiver, and the context in which care is given, such as the types of supports available to an increasingly diverse caregiving population.[2] This Health Management Associates (HMA) study focuses on a limited set of HCBS supports funded through the Alternative Care (AC), Elderly Waiver (EW), and Older Americans Act (OAA) programs. Services and associated data in the study center on older adults who need HCBS, their caregivers, and the set of supports and providers of those services that form the HCBS ecosystem.

Recognizing that many of the services offered through the AC, EW, and OAA programs have a more direct relationship with older adults with HCBS needs, HMA chose to focus on the scale and impact of three key domains—older adults with HCBS needs, family caregivers, and support services—with the goal of expanding the intersection where all three meet (see Figure 1).

Figure 1. Relationship of Older Adults with HCBS Needs, Support Services, and Family Caregivers



The purpose of the HMA study was to describe aspects of the existing HCBS service system, including demographic and service trends, and to identify strengths and opportunities to improve access to supports for older Minnesotans and their caregivers, with an intentional focus on the experience of diverse communities. In addition, the HMA team sought to identify successful local and national models that may inform recommendations for improving service systems.

This report defines Minnesota-specific patterns in the use of HCBS, places them in a national context, and analyzes demographic differences among Minnesota subpopulations across categories of geography, race, ethnicity, language, and gender identity, noting that being a caregiver from a historically marginalized population is a predictor of increased burden.[3] Finally, HMA offers three recommendations on how to further Minnesota's innovative models of respite care, support for caregivers, and HCBS reforms, drawing from both national and local research to continue progress toward a seamless system of supports.

CURRENT PROGRAM ALIGNMENT

An Overview of HMA's Project Proposal

HMA identified four key priorities when selecting programs and services to study opportunities to enhance HCBS for older adults and caregivers:

- Increase continuity of care as individuals and caregivers transition across programs
- Effect changes that will enhance the robust scope of services offered across programs
- Improve coordination across existing, large, experienced program entities
- Increase the volume of program participants

HMA identified system and programmatic alignment opportunities as a central focus of the study. The HCBS programs studied in our project include the EW, AC, and OAA programs (see Table 1).

Table 1. Programs Studied

Program Name	Total Program Participants in Fiscal Year 2021	Program Authority	State Regulatory Authority
Elderly Waiver	28,180	Medicaid 1915	MN DHS
Alternative Care	2,655	Medicaid 1115	MN DHS
Older Americans Act	19,252	Older Americans Act/ Title III	MN Board on Aging (MBA)

Though these are three distinct programs, they do offer some continuity across HCBS services. Services studied include primary support for caregivers, identified as caregiver training and education, caregiver coaching and counseling, and respite. Secondary supports are those that likely ease caregiver burden but do not directly support caregivers. Secondary services include adult day services (ADS), personal care assistance (PCA), and homemaker, companion, and individual community living supports (ICLS). For the purpose

of this project, the subset of services selected was based on continuity across program types and the degree to which supports would have a meaningful impact (see Table 2).

Table 2. Number of Individuals Accessing Key Services by Program, State Fiscal Year 2021

Services	Alternative Care (AC)	Elderly Waiver (EW)	Older Americans Act (OAA)
Caregiver Support Services[4]	2	17	3,081
Respite	40	85	550
Adult Day Services	47	4,009	N/A
Personal Care Assistance[5]	656	8,966	N/A
Homemaker	1,454	9,618	2,406
Companion	43	534	N/A
Individual Community Living Support	429	973	N/A

Other services provided in AC, EW, and OAA programs that are supportive to caregivers in Minnesota were excluded from the study. Several other programs and initiatives affect older adults and their caregivers were outside of the primary scope for this project but should be considered as Minnesota expands the system supporting caregivers, including:

- Live Well at Home grants
- Senior Volunteer Programs: Senior Companion and RSVP
- Local and Regional Dementia Grants

- Return to Community
- Essential Community Supports Program
- State Plan Home Care Program

Program Comparisons

Key elements of the AC, EW, and OAA programs were researched and identified for consideration of solutions that will be most meaningful for Minnesota to pursue. Internet research, document review and interviews with DHS and programmatic subject matter experts (SMEs) were completed to inform a comparison of programmatic elements.

Of note, county assessors/case managers manage the AC program and have oversight authority for a small percentage of individuals enrolled in EW. Because most EW services are managed through programs that managed care organizations (MCOs) administer, HMA's analysis reflects only MCO processes for EW and county processes for AC. Any county-managed EW service follows a similar process to the AC case manager work described in this report. Tribes also manage AC and EW services following similar processes with some variance as permitted by program policies.

Definitions of Caregiver Across Programs

Programmatic Element	AC Definition of Caregivers	EW Definition of Caregivers	OAA Definition of Caregivers
Current Definitions of Caregiver across Programs	Informal or primary caregivers are family, friends, neighbors, and others who provide services and support to an aging adult. These caregivers receive no compensation for their services or support. Informal caregivers provide routine, dependable support and assistance.[6]	Informal or primary caregivers are family, friends, neighbors, and others who provide services and support. These caregivers receive no compensation for their services or support. Informal caregivers provide routine, dependable support and assistance.[7]	Senior Linkage Line /Minnesota Board on Aging (MBA)[8] definition: Individuals who help an aging parent, spouse, or friend on a regular, unpaid basis.[9]

The definition of caregivers varies across programs and guidance resources. The Minnesota Board on Aging (MBA) webpage displays a definition, which differs from the working Title III-E definition that Area Agencies on Aging (AAA) use to operationalize services and supports:

OAA Caregiver Supports (Title III-E services) shall be provided to all eligible persons as defined below:

1) Caregivers who are 60 years of age or older and an adult family member, or other individual, who is an informal provider of in-home and community care; the caregiver and care receiver do not necessarily live together. Caregivers of any age, who is an adult family member or other individual who is an informal provider of in-home and community care to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction, the caregiver and care receiver do not necessarily live together. Caregivers who are 55 years of age or older and a grandparent or older relative caregiver (excluding grandparents) of a child younger than 18 years old; this includes a grandparent, step-grandparent, or a relative of a child by blood, marriage or adoption and is an informal provider of in-home and community care.
    a) The caregiver:
        i) Lives with the child
        ii) Is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child
        iii) Has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally
2) Caregivers who are age 55 or older and a parent, grandparent, or other older relative by blood, marriage, or adoption of an individual with a disability [as defined in Section 3 of the Americans with Disabilities Act of 1990 (42 USC 12103)] ages 19-59 and is an informal provider of in-home and community care
    a) The caregiver:
        i) Lives with the individual. The term ''family caregiver'' means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual or to an individual of any age with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction.
3) The term ''older relative caregiver'' means a caregiver who:
    a) Lives with the individual. The term ''family caregiver'' means an adult family

member, or another individual, who is an informal provider of in-home and community care to an older individual or to an individual of any age with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction. The term ''older relative caregiver'' means a caregiver who:

i) Is age 55 or older

ii) Lives with, is the informal provider of in-home and community care to, and is the primary caregiver for, a child or an individual with a disability

4) In the case of a caregiver for a child:

a) Is the grandparent, step grandparent, or other relative (other than the parent) by blood, marriage, or adoption, of the child

b) Is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregivers of the child

c) Has a legal relationship to the child, such as legal custody, adoption, or guardianship, or is raising the child informally in the case of a caregiver for an individual with a disability, is the parent, grandparent, or other relative by blood, marriage, or adoption, of the individual with a disability

Identification of Caregivers

Programmatic Element	Identification of Caregivers in AC	Identification of Caregivers in EW	Identification of Caregivers in OAA
Identification of Caregivers	Occurs during initial assessment and reassessments through the MnCHOICES assessment process conducted by county staff	Occurs during initial assessment and reassessments through an MCO care coordinator, typically during LTCC assessment, but may be identified outside of assessment processes	Engaged by caregiver consultants in any number of places such as community connections, transitional care units, or referrals from healthcare provider

The mechanism for identifying caregivers plays a significant role in how and when they first learn of services or sign up for available supports. The service access pattern for primary caregiver supports in the OAA programs is driven heavily by provider engagement with caregivers, then follow up with AAA to ensure payment. In OAA programs, until a provider

engages a caregiver, no caregiver assessment activity takes place that may identify an older adult and/or a caregiver who would benefit from assistance.

In contrast, AC and EW programs proactively seek to identify caregivers as part of each program's requirement for outreach, annual assessments, and scheduled interventions throughout the year. In both AC and EW, the assessment includes multiple questions to identify caregiver involvement.

Though the AC and EW program offer a more comprehensive approach to identifying caregivers for enrollees, they have no means of stratifying or distinguishing and recording the frequency, intensity, or effectiveness of caregiving activities. For example, an older adult could identify one caregiver who lives hours away but periodically checks in and another who provides daily hands-on support. To ensure that the older adult has adequate support, it is crucial that the data collected in the assessment process is analyzed and recorded in a manner that can be easily acted upon.

Beyond the issue of identifying and analyzing existing caregiving is the question of how and when programmatic resources are deployed to meet the older adult's needs and preferences. The OAA program is unique because primary caregiver services are not tethered to the eligibility or service needs of the care recipient. Instead, once a caregiver is identified, the focus in an OAA program is directly on the caregiver's experience. Caregiving activities are independent of assessment or service budget of the care recipient. SMEs interviewed explained that engagement with caregivers happens organically in the community and in other supported environments (e.g., transition care units, nursing homes, etc.) where caregiver consultants are located.

Qualifying for Caregiver Supports

Programmatic Element	Qualifications for AC Caregiver Supports	Qualifications for EW Caregiver Supports	Qualifications for OAA Caregiver Supports
How Caregivers Qualify for Supports	Based on the need of the older adult, who must meet NFLOC. Once NFLOC is established, the assessor first discusses older adult supports with the individual (secondary services) and secondarily will address caregiver supports	Based on the need of the older adult, who adult must meet NFLOC. Some MCOs also offer Medicare Supplemental Benefit caregiver supports and will identify/refer those supports as applicable regardless of NFLOC eligibility	Based on the caregiver, providers, primarily caregiver consultants, engage caregivers and explain service options and availability. If the caregiver agrees, the provider will proceed with assessment and creation of a caregiver support plan

In contrast, programmatic requirements in both the AC and EW programs delay the initiation of caregiving services. Before the caregiver can receive services, older adults must first demonstrate that they meet nursing facility level of care to access EW or AC services. Another delay results from the prioritization of the service planning discussion, which first focuses on the older adult's needs. Typically, the discussion of caregiver supports occurs later and must fit into the budget allotted for other waiver services that an older adult needs. Some MCOs offer Medicare Supplemental Benefits that support caregivers. These MCOs have care coordinators who are trained to identify and explain other non-EW supports available to caregivers and coordinate accordingly.

A caregiver support outcome measurement strategy that cuts across AC, EW, and OAA has yet to be put in place. The most notable activity is an annual caregiver survey that occurs only in the OAA program. More than a decade ago, the OAA program implemented this questionnaire to measure caregivers' perceptions of improved or extended care resulting from OAA services. AAAs and the state have gleaned information from these surveys to develop more responsive caregiver services. It is the only form of caregiver supports outcome measurement in place. EW and AC assessors may inquire about satisfaction with services during the annual assessment, and AC case managers and EW care coordinators are responsive to problems with services that arise and could result in poor outcomes.

Assessing Caregiver Needs

Programmatic Element	AC Caregiver Assessments	EW Caregiver Assessments	OAA Caregiver Assessments
Caregiver Assessments	County assessors complete the MnCHOICES Caregiver Module. If a referral is made and the caregiver agrees to participate in caregiver coaching, the caregiver undergoes a detailed assessment.	MCO CCs complete the LTCC Caregiver Assessment section. If a referral is made and the caregiver agrees to receive caregiver coaching, this service includes a detailed caregiver assessment. Some MCOs have started to offer targeted caregiver benefits that may result in other assessments, additional supports, and benefits outside of the Medicaid benefit set that is not reflected in state data.	Caregiver assessments only occur once a caregiver agrees to engage with a caregiver consultant. The caregiver consultant provider group is the only avenue for caregiver assessment activity.

Caregiver assessments are extremely important, not just for purposes of identifying and authorizing services that will benefit these individuals, but also as a key awareness-building activity. When family members who don't self-identify as caregivers are asked assessment questions that resonate with their own experiences, they realize they are engaging in caregiving activities and that other parties view them as caregivers.

The OAA assessments that caregiver consultants conduct are the most robust; however, due to the nature of service provision, the OAA volume is lower than LTCC/MnCHOICES EW and AC assessments. In AC and EW, caregivers are identified through the numerous questions asked during the older adult assessment. Beyond the identification process, AC case managers and EW care coordinators must evaluate whether caregivers need coaching and counseling. However, because the caregiver assessment activity is secondary to the older adult assessment, caregivers are less likely to receive adequate focus.

Planning and Budgeting for Caregiver Services

Programmatic Element	Planning and Budgeting for Caregiver Services in AC	Planning and Budgeting for Caregiver Services in EW	Planning and Budgeting for Caregiver Services in OAA
Caregiver Services Planning and Budgeting	Occurs as part of the older adult service planning activity; AC budget caps apply to services for both the older adult and caregiver support services.	Occurs as part of the older adult service planning activity; EW budget caps apply to services for both the older adult and caregiver support services. Some MCOs have started to offer additional caregiver supports that may result in additional supports and benefits outside of Medicaid policy coverage criteria.	Primary caregiver services are coordinated by the caregiver consultant. There is no set budget.

Only the OAA program offers a consistent, separate, designated focus on caregiver needs. Under this program, the caregiver consultant creates a caregiver-specific support plan that may fall outside a larger budget for the care recipient's services. Under AC and EW, caregiver support planning involves service discussions and considerations that occur after the older adult's service needs are identified and addressed. All services in the AC and EW plan must fit in with the older adult's budget, including caregiver support costs. This arrangement can prove problematic if the older adult's service needs are high, with caregivers generally foregoing supports if a budget cannot meet the needs of both the care recipient and caregiver.

The structure of the AC and EW budget may create barriers to caregivers' willingness to accept services that must be paid out of the care recipient's allotted funds if they feel uncomfortable about needing help.

If caregiver support services do not fit into the AC or EW budget, case managers and care coordinators could make referrals to OAA programs. Research about caregiver supports

conducted in 2020[10] and SME interviews for this project indicate that AC case managers and EW care coordinators need further education about the availability of their respective program's caregiver support services. Additionally, these individuals appear to have limited awareness that additional caregiver supports are available through OAA programs when a waiver budget has capped out.

Use of Caregiver Supports

Programmatic Element	Utilization of AC Caregiver Support Services	Utilization of EW Caregiver Support Services	Utilization of OAA Caregiver Support Services
Caregiver Support Services Utilization[11]	Low 2 caregivers served in SFY 2021	Low 17 caregivers served in SFY 2021	High 3,081 caregivers served in SFY 2021

Of the services within the scope of this project, coaching and counseling and training and education most directly target support to the caregiver and offer supports beyond respite. Research on caregiver supports conducted in 2020[12] found little use of these specific caregiver services in EW and identified a need for further education on these supports. Even less visible to AC case managers and EW care coordinators is that the provider community that offers caregiver coaching and counseling and caregiver training and education is composed completely of caregiver consultants. Data analysis for this project demonstrates low utilization in AC and EW, with significantly higher use in OAA. This finding underscores the need for strengthened education and awareness of the caregiver coaching and counseling and caregiver training and education available through OAA. Underscoring this need is the low use in AC and EW programs, which identify caregivers more consistently through routine and ongoing assessment.

Role of Caregiver Consultants in Services and Programs

Programmatic Element	Role of Caregiver Consultants in AC Services and Programs	Role of Caregiver Consultants in EW Services and Programs	Role of Caregiver Consultants in OAA Services and Programs
Role of Caregiver Consultants in Services and Programs	Not visible to case managers. If referrals for caregiver coaching and counseling are made, because of enrollment policies, the providers by default will be a caregiver consultant.	Not visible role to care coordinators. If referrals for caregiver coaching and counseling are made, due to enrollment policies, the providers by default will be a caregiver consultant.	Primary role in terms of all caregiver support and assessment activity.

Caregiver consultants conduct and develop the assessments and support plans for OAA programs. The EW care coordinator survey as well as conversations that occurred to inform the 2020 research indicated minimal awareness of caregiver consultant services and a general lack of knowledge regarding the role of caregiver consultants. The waiver programs' service definitions for caregiver coaching and counseling list different types of professionals who are authorized to provide caregiver support planning. Though it appears other professionals could also provide services, when providers enroll through DHS for these service categories, they are required to provide information on when they became caregiver consultants. Thus, by nature of the operational requirements of DHS provider enrollment, it is mandatory that all caregiver coaching and counseling providers be caregiver consultants. Most stakeholders, including AC case managers and EW care coordinators, are unfamiliar with this mandate.

Other Supports Available to Caregivers

Programmatic Element	Other AC Caregiver Supports	Other EW Caregiver Supports	Other OAA Caregiver Supports
Other Caregiver Supports (outside of programmatic funding sources)	County-specific resources as applicable and other resources identified in Minnesota Help.info	MCO care coordinators may have their own resources and are encouraged to use MinnesotaHelp.info. MCOs may provide additional navigation resources and MCO supplemental benefits as applicable.	Caregiver education and support platform and caregiver consultant-recommended resources based on community expertise

Caregiver supports outside of funding in AC, EW, and OAA HCBS programs also affects the sustainability of the caregiver's role. One such support is Trualta, a caregiver education and support platform. Trualta is available only to caregivers who have engaged with caregiver consultants in MN OAA programs. AAAs, state agencies, payers, providers, and community-based organizations (CBOs) in 26 other states use Trualta. The platform has print, audio, video, and eLearning modules on population-specific challenges to impart caregiving skills and greater confidence to family caregivers.

A 2021 study conducted at the University of Florida showed that this platform is an effective way to teach caregivers of older adults with dementia at least one skill and a means of improving self-care.[13] Studies on other caregiver education and support platforms have produced similar results. An identified limitation of OAA's current use of the Trualta platform is that the caregiver cannot independently access the platform's tools, trainings, and resources. The requirement that caregivers engage with caregiver consultants to gain direct access to Trualta limits or delays access to the tools and supports available through the platform.

Access to additional resources in both the AC and EW program are limited by factors such as limitations and strain on county-specific resources, infrequent or irregular updating of resources available through publicly accessible websites, and general knowledge of the depth and scope of supports available in a particular geographic area. AC case managers can access county-specific resources and other relevant information from MinnesotaHelp.info. Similarly, in the EW program, care coordinators often refer to

MinnesotaHelp.info. EW coordinators, either as employees or delegates of MCOs, often have access to resources that the MCOs have established to support care coordinators. MCOs are increasingly offering unique supplemental benefits (a benefit category funded by Medicare Advantage [MA] plans) that support caregivers. MCOs are required to train their care coordination teams on the availability of supplemental benefits annually.

Caregiver Service and Support Navigation

Programmatic Element	Caregiver Service and Support Navigation in AC	Caregiver Service and Support Navigation in EW	Caregiver Service and Support Navigation in OAA
Caregiver Service and Support Navigation	County assessor and case managers primarily navigate supports for caregivers (one annual face-to-face visit is the minimum requirement). Caregiver consultants are available through caregiver coaching and counseling services, but these services are rarely used.	Care coordinators primarily navigate supports for caregivers (one annual face-to-face visit is the minimum requirement). Caregiver consultants are available through caregiver coaching and counseling services, but these services are rarely used.	Caregiver consultant; AAA models do not include case or care management.

Access to caregiving resources is directly shaped by awareness and engagement with various resources. Hence, the type and training of the professional who is tasked with helping caregivers navigate supports and benefit options will directly affect access to resources.

In the OAA programs, the caregiver interacts with a caregiver consultant in the community or location of the older adult care recipient (individual residences, transitional care units, skilled nursing facilities, and continuing care retirement communities). As a result, the support planning for caregivers happens organically. In AC and EW programs, the caregiver navigator role typically defaults to the AC case manager or EW care coordinator assigned to the older adult enrollee, who is the case manager's and care coordinator's first priority. Though it is a best practice is to meaningfully engage caregivers as part of that work, this level of engagement does not always happen.

Despite their best intentions, AC case managers and EW care coordinators cannot always give adequate attention to caregivers. Since their inception, the demands on case managers and care coordinators have grown significantly and become increasingly complex, resulting in a heavier burden to meet the needs of the primary client—the older adult—and less time to focus on caregivers.

Ideally, across all three programs, the cadence of interaction should match the caregiver's level of need, and the frequency of interaction should reconfigure if a caregiver's or older adult's circumstances change. AC case managers and EW care coordinators are required to meet minimum engagement standards with the older adult (i.e., annual assessments are required, etc.) Though AC case managers and EW care coordinators are expected to meet with and assess the caregiver regularly, there is no explicit requirement that this contact happens. OAA navigator supports are less routine; thus, caregivers may request interaction as needed.

Training Key Programmatic Care Support Navigators

Programmatic Element	Training Key AC Programmatic Caregiver Support Navigators	Training Key EW Programmatic Caregiver Support Navigators	Training Key OAA Programmatic Caregiver Support Navigators
Training of Key Programmatic Caregiver Support Navigators	Case manager training on completion of caregiver assessments and how to support caregivers is embedded in training processes for completing the assessment and care plan for the qualifying older adult enrollee.	Care coordinator training on completion of caregiver assessments and support for caregivers is embedded in training processes for completing the assessment and care plan for the qualifying older adult enrollee.	Caregiver consultants must meet detailed training requirements covering nine different standards with a focus on eight specific core competencies. The training process includes online learning (TrainLink) in addition to a one-day in-person session.

Of the AC, EW, and OAA programs, caregiver consultants receive the most caregiver-specific training. As part of their job training, AC case managers and EW care coordinators learn how to complete the caregiver assessment modules and incorporate caregiver needs into the overarching care and service plans for older adults enrolled in AC and EW. Feedback from surveying the EW care coordinators (some of whom are likely also AC case managers) in 2020 about caregiver services underscored a need for more focused training on caregiver support benefits.

Caregiver consultants must meet the Caregiver Consultant Standards for Professional Practice set forth by the Minnesota Board on Aging (MBA). Caregiver consultants complete virtual basic training, followed by in-person or virtual continuing education that AAA offers. Caregiver consultants must, at a minimum, have knowledge of HCBS and publicly funded, means-tested public benefits to meet the professional qualifications established under Standard 1. SMEs interviewed for this study identified an opportunity for both the AC and EW programs to improve the training available to AC case managers and EW care coordinators on caregiver supports available in HCBS and OAA programs. Improving the knowledge base of AC case managers and EW care coordinators in these areas would increase access to other key services and supports that would benefit caregivers.

Case Transfers and Warm Handoffs

Programmatic Element	Case Transfer and Warm Handoff Practices in AC	Case Transfer and Warm Handoff Practices in EW	Case Transfer and Warm Handoff Practices in OAA
Case Transfer and Warm Handoff Practices	Warm handoff to county EW worker (the next operational step before being assigned to an MCO). Not in place for AAA referrals.	Not in place	Not in place

Effective transitions or warm handoffs between programs when an older adult gains eligibility for a new program could be improved. Under the OAA program, the focus on the caregiver makes tracking a recipient's enrollment in AC or EW difficult. The lack of effective transitions also creates challenges for newly assigned AC case managers or EW care coordinators. Without consistent, planned transition processes, it is difficult for a newly

assigned AC case manager or EW care coordinator to have sufficient information about existing caregiver consultant services and supports available to caregivers at the point of the transfer. This disconnect can create disruptions and added stress for the older adult and the caregiver.

HCBS programs must use the HCBS Waiver, AC and ECS Case Management Transfer and Communication Form (DHS-6037) for case transfers. The programs listed on the form omit OAA HCBS services, as the form is intended for MCO, county, and tribal agency use. The form does not have a specific field to identify caregivers but does have fields for the guardian/conservator and payee/authorized representative. Ideally, the caregiver support information could be documented in an open text box for recording transfer notes, the community support plan, or services/supports to avoid inconsistent practices and expectations.

Outcome Measurement

Programmatic Element	Outcome Measurement of AC Caregiver Supports	Outcome Measurement of EW Caregiver Supports	Outcome Measurement of OAA Caregiver Supports
Outcome Measurement of Caregiver Supports	Annual assessment of care recipient includes some service satisfaction questions	Annual assessment of care recipient includes some service satisfaction questions	Annual Caregiver Survey

No caregiver support outcome measurement strategy that cuts across AC, EW, and OAA is in place. The most notable activity is an annual caregiver survey that only the OAA program conducts. More than a decade ago, the OAA program implemented this questionnaire to measure caregivers' perceptions of improved or extended care resulting from OAA services. AAAs and the state have gleaned information from these surveys to develop more responsive caregiver services. EW and AC assessors may ask about satisfaction with services during the annual assessment, and AC case managers and EW care coordinators are responsive to problems with services that could result in poor outcomes.

Return on Investment Measurement

Programmatic Element	ROI Measurement of AC Caregiver Supports	ROI Measurement of EW Caregiver Supports	ROI Measurement of OAA Caregiver Supports
ROI Measurement of Caregiver Supports	None	None	None

None of the three programs analyzes the return on investment (ROI) for caregiver support services. Medical claims data are key to ROI analysis, but DHS has not collected this information for the AC and OAA programs. EW does have medical claims data, and DHS could conceivably implement ROI analysis in EW. Though the caregiver populations that the respective programs serve vary, aligning AC, EW, and OAA caregiver supports likely would allow inferences about ROI for all three programs to then be drawn from EW ROI data.

Alignment of HCBS Provider Networks

The role of provider networks for primary and secondary caregiver supports services plays a significant role in access and availability of needed supports. Minnesotans and caregiver/HCBS navigators primarily use two resources to locate providers—the DHS-enrolled HCBS provider network and the MinnesotaHelp.info database.

The DHS HCBS provider network is composed of providers who enroll through DHS to serve participants in Medicaid programs. Of note, this provider network includes providers serving both aging and disability waiver populations and is the provider network for AC and EW program participants and caregivers. The MCOs that administer EW receive a provider enrollment file (the "PECD") at least monthly. Counties that administer AC do not receive a file and must leverage the DHS online provider directory. The following disclaimer is listed on the landing page of this directory:

> ## Home and Community Based Service Providers
>
> **This directory may not have all home and community-based providers listed.**
>
> **If you are searching for home and community-based services and waiver providers, also visit MinnesotaHelp.info**

MinnesotaHelp.info is a state-sponsored database that serves all of Minnesota. The focus has evolved over the years and has been refined to center largely on older Minnesotans and caregivers. Several official data sources inform and support the database. Since 2013, MinnesotaHelp.info has had a connection to the DHS data warehouse to access provider information for HCBS providers participating in the waiver programs. The database undergoes multiple validations steps and checks, with staff updating and modify provider data with greater ease and fewer regulatory restrictions as it is the unofficial Medicaid-enrolled provider directory. MinnesotaHelp.info offers advanced search capability and has optional fields where providers can indicate cultural and linguistic capability and service area. MinnesotaHelp.info staff partner with the MBA and the Senior Linkage Line to maintain this database.

At the beginning of this research project, the HMA team was advised to leverage the MinnesotaHelp.info network information to assess provider participation and activity. Through the exploration process we learned about the investment of AAA resources to maintain and groom the MinnesotaHelp.info database. During the analysis of network composition, we identified discrepancies between MN DHS Provider Enrollment files and MinnesotaHelp data. Consequently, HMA was instructed to use the MN DHS Provider Enrollment files for our network analysis and leverage a separate file reflecting some AAAs provided network provider information for the purpose of our research.

HMA researched key elements supporting the existence and success of provider networks available to the AC, EW, and OAA programs and identified solutions that would have the greatest impact on older Minnesotans and their caregivers. Feedback gathered from an AAA survey of their HCBS network providers as part of the Minnesota Caregiver Supports Improvement Plan research in 2020 also informed the following recommendations.

HCBS Provider Network Enrollment Processes

Network Element	HCBS Provider Enrollment Processes for AC	HCBS Provider Enrollment Processes for EW	HCBS Provider Enrollment Processes for OAA
Provider Enrollment Processes	Enrolls through DHS provider enrollment processes	Enrolls through DHS provider enrollment processes	AAA network contract managers execute contracts with providers

Within OAA programs, HCBS providers have a specific contact—the AAA contract manager. This individual guides the AAA HCBS provider contracting process and assists the provider in becoming an HCBS provider in an AAA region/OAA programs. The AAA contract manager also can help the provider navigate operational processes and billing. Some AAAs offer additional engagement forums to providers to support their effectiveness in meeting older adult and caregiver needs and sharing best practices.

HCBS Provider Enrollment Support Systems

Network Element	AC Enrollment Supports	EW Enrollment Supports	OAA Enrollment Supports
Enrollment Supports Available	MN DHS provider enrollment; counties may offer guidance in extreme cases	MN DHS provider enrollment; MCOs may offer guidance in extreme cases	AAA contract manager primary support; Eldercare Development Partnership (EDP) staff may support

AAA contract managers are the primary supports for OAA HCBS network providers. Each HCBS provider has an individual contact at the AAA. In addition, the Eldercare Development Partnership (EDP) staff are available at AAAs. The EDPs provide technical assistance to local providers to develop and implement service delivery models. Technical assistance activities of the EDP include working with both public and private LTSS providers to collaboratively develop sustainable proposals for systems change, accessing the State's Live Well at Home Grants and/or other resources as appropriate.

Even though EDPs are charged with increasing statewide capacity of HCBS providers by providing technical assistance, our SME interviews and 2020 caregiver support research

indicated that EDP staff do not support HCBS provider enrollment issues in the EW, or AC programs. It has been several years since EDP staff received training in the basics of managed care EW programs, and consequently, EDPs lack the operational knowledge necessary to provide technical assistance to HCBS providers who have enrollment questions.

Resources to Help HCBS Providers Address Billing Issues

Network Element	Troubleshooting AC Billing and Reimbursement Issues	Troubleshooting EW Billing and Reimbursement Issues	Troubleshooting OAA Billing and Reimbursement Issues
Troubleshooting Billing and Reimbursement Issues	MN DHS Provider Enrollment	MCO provider services	AAA contract manager primary support

Reimbursement concerns have consistently and increasingly been a focus of HCBS programs. Inefficient payment processes drive increased administrative provider costs, which further exacerbate ongoing HCBS workforce challenges. To recruit and maintain the direct care community-based workforce, HCBS providers must keep reimbursement for individual HCBS workers competitive and sustainable. In the same vein, for HCBS provider entities to remain financially solvent, administrative provider billing expenses must be minimized.

HCBS providers serving AC, EW, and OAA programs must interface with different billing entities to obtain reimbursement. Under the Minnesota HCBS structure, alignment of payer source is infeasible, but opportunities to align, simplify, and strengthen provider administrative supports are evident.

In OAA programs, the AAA contract managers are the primary supports to HCBS network providers. OAA has achieved some degree of programmatic simplicity for HCBS providers by assigning HCBS providers to a designated contact at the AAA. One area where provider administrative supports could be strengthened is by clarifying EDP staff accountability for providing technical assistance with billing and reimbursement issues. Currently, EDP staff are charged with providing “technical assistance” to HCBS providers statewide, but this mandate does not specify the extent to which EDP staff are expected to navigate billing and reimbursement issues within AC and EW HCBS programs.

All AC programs leverage the MN DHS-enrolled HCBS network of providers. For billing issues in AC or county-managed EW, providers are referred to the MN DHS Provider Support call center. For billing issues in EW through the MCOs, HCBS providers should work with the MCO provider services call center for support. Some HCBS providers may encounter difficulty interfacing with MCO provider services staff because they may have insufficient training on HCBS service requirements and processes. Further complicating the process, each of the eight EW MCOs may have slightly different billing requirements, and HCBS providers work with each individual MCO provider support call center for resolution.

Composition of HCBS Provider Networks in AC, EW and OAA Programs

Network Element	AC HCBS Provider Networks	EW HCBS Provider Networks	OAA HCBS Provider Networks
HCBS Providers Providing Primary and Secondary Services within HCBS Programs	All DHS-enrolled HCBS providers.	All DHS-enrolled HCBS providers.	All AAA-contracted HCBS providers.

HMA's HCBS program network analysis sought to identify the volume of HCBS providers meeting current service needs. OAA HCBS provider network data were provided, representing any OAA provider contracted with an AAA in 2021−2022 with a paid claim. HMA also constructed the Active Provider category to analyze the AC/EW network to similarly identify the subset of providers that had a paid claim in 2022. It is important to view the AC/EW HCBS provider network from this perspective because the number of enrolled providers may exceed the number of actual providers at any given time. The reasons for these variances include: workforce longevity and availability within service groups, how providers enroll (able to sign up for multiple services regardless of intent or workforce capacity), and the fact that enrolled provider status spans multiple years, with providers having little incentive to terminate their enrolled status when they stop providing services.

Tables 3 and 4 outline how many providers are enrolled or contracted to meet AC, EW, and OAA HCBS program needs across primary in-scope services and secondary services.

Table 3. Volume of HCBS Providers Offering Primary Caregiver Support Services

Primary Caregiver Support Services	OAA Providers Offering Primary Caregiver Support Services	EW/AC Active Providers Offering Primary Caregiver Support Services	Total EW/AC Providers Offering Secondary Caregiver Support Services
(Adult) Companion	N/A	47	1,804
Adult Day Services	1	143	555
Caregiver Coaching and Counseling	53	0	539
Caregiver Training and Education	18	5	428
Homemaker	29	420	1,695
ICLS	N/A	227	-
Personal Care Assistance	N/A	91	2,812
Respite	34	54	2,746

Table 4. Volume of HCBS Providers Offering Secondary Caregiver Support Services

Secondary Caregiver Support Services	OAA Providers Offering Secondary Caregiver Supports	EW/AC Active Providers Offering Secondary Caregiver Supports	Total EW/AC Providers Offering Secondary Caregiver Supports
Chore	27	59	632
Customized Living	N/A	630	706
Environmental Adaptation	5	55	654
Extended Home Health Aide Services	N/A*	39	236
Extended Personal Care Assistance	N/A	39	153
Home Health Aide	N/A	86	152
Home-Delivered Meals	1	83	405
Lifeline/Personal Emergency Response Systems (PERS)	N/A	50	-*
Skilled Nursing	N/A	102	396
Supplies and Equipment	N/A	94	1,164
Transportation	35	207	1,217

*N/A means that either the program does not offer the service or HMA did not receive provider information. "-" means information about the service was omitted from the file but is a covered

service.

The active provider, as described above, is an important concept when considering provider capacity and drivers of access challenges; however, it also is important to consider the limitations of this analysis, such as not knowing how many direct care professionals are providing services at each provider entity to meet service needs.

Figure 2 identifies the percentage of AC/EW HCBS active providers in the primary supports group, and Figure 3 centers on active providers in secondary supports.

Figure 2. Active AC/EW HCBS Providers of Primary Caregiver Supports

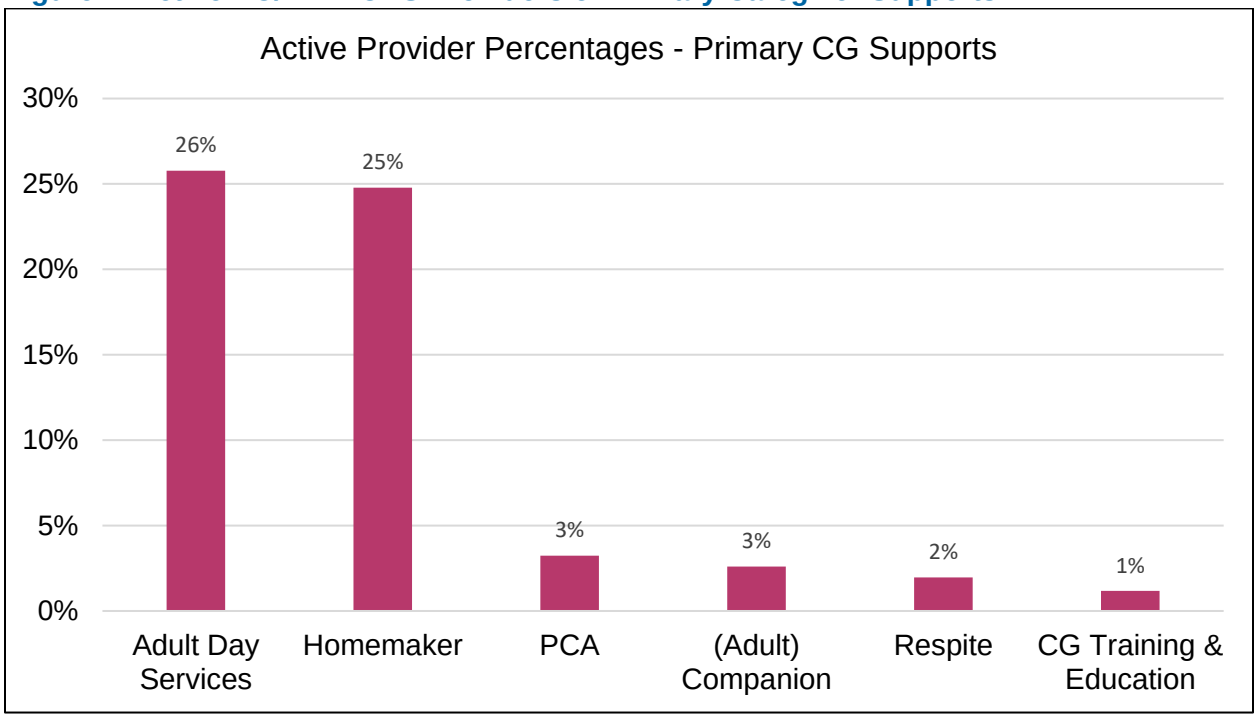
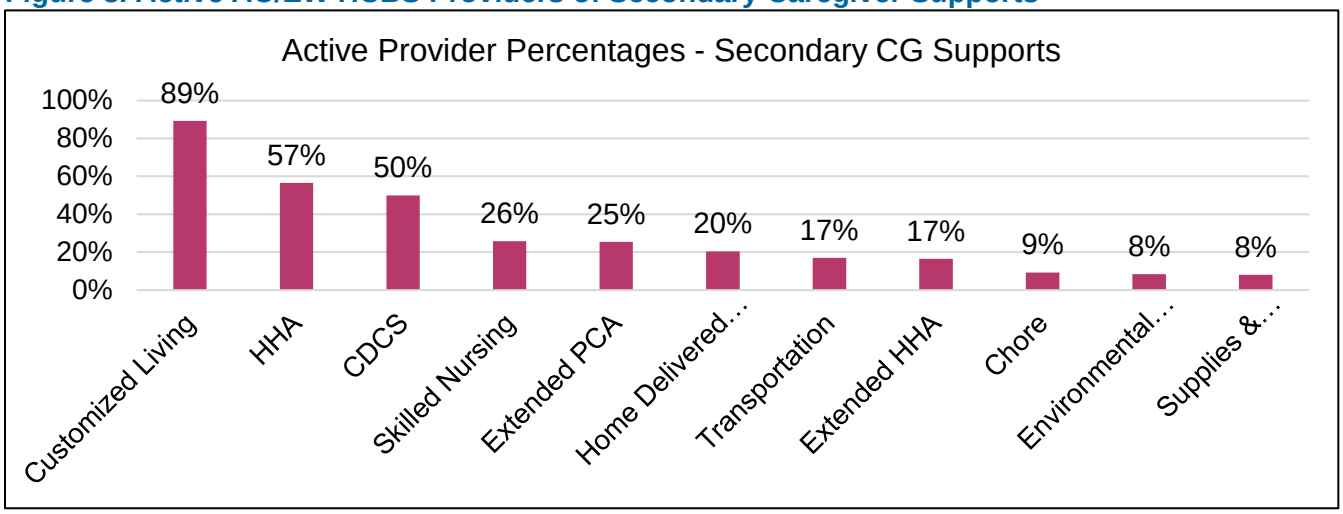


Figure 3. Active AC/EW HCBS Providers of Secondary Caregiver Supports



Network Element: HCBS Providers Enrolled to Offer Multiple HCBS Services

HMA sought to understand the degree to which certain primary and secondary in-scope service providers were enrolled across service categories. DHS Advisory Committee experts shared their belief that there is significant overlap in certain HCBS service categories across enrolled/contracted providers.

Overlap in provider services is an important consideration when contemplating different workforce cultivation strategies. With this information DHS could decide to target efforts to attract staff with skill sets that can effectively meet the professional and technical requirements of key caregiving support services to address workforce strain. For example, adult day service (ADS) providers frequently interface with and support caregivers. ADS providers may be able to more easily meet current requirements to enroll as caregiver coaching and counseling providers in addition to being enrolled ADS providers. One strategy could be to intentionally outreach to ADS providers about cultivating the caregiver consultant workforce. Tables 5 and 6 show an analysis of AC and EW providers enrolled across the different HCBS services.

Table 5. Primary Supports AC/EW Active Providers Enrolled Across Service Categories

Count of Active AC/EW Service Providers by Service Provided	AC/EW Respite Providers	AC/EW Adult Day Services Providers	AC/EW Caregiver Training and Education	AC/EW Homemaker Providers	AC/EW ICLS Provid-ers	AC/EW PCA Provid-ers
Respite	**122**	3	1	87	47	52
ADS	3	**182**	-	15	3	2
Caregiver Training and Education	1	-	**6**	3	-	-
Homemaker	87	15	3	**622**	196	280
ICLS	47	3	-	196	**296**	107
PCA	52	2	-	280	107	**417**

Table 6. Secondary Supports AC/EW Active Providers Enrolled Across Service Categories

Count of Active AC/EW Service Providers by Service Provided	AC/EW CDCS Providers	AC/EW Chore Providers	AC/EW Customized Living Providers	AC/EW Environmental Adaptation Providers	AC/EW Extended HHA Providers	AC/EW Extended PCA Providers	AC/EW HHA Providers	AC/EW Home-Delivered Meals Providers	AC/EW PERs Providers	Skilled Nursing Providers	AC/EW Supplies and Equipment Providers	AC/EW Transportation Providers
Chore	-	**93**	1	15	2	3	3	6	2	3	17	35
Customized Living	-	1	**1,169**	-	8	4	30	32	6	32	2	7
Environmental Adaptation	1	15	-	**79**	1	-	1	1	4	1	27	13
Extended HHA	-	2	8	1	**63**	4	52	5	7	55	5	3
Extended PCA	1	3	4	-	4	**157**	11	-	-	15	2	3
HHA	-	3	30	1	52	11	**141**	12	15	139	6	5
Home Delivered Meals	-	6	32	1	5	-	12	**145**	6	11	3	21
PERs	-	2	6	4	7	-	15	6	**75**	15	25	1
Skilled Nursing	-	3	32	1	55	15	139	11	15	**188**	7	5
Supplies and Equipment	1	17	2	27	5	2	6	3	25	7	**124**	14
Transportation	-	35	7	13	3	3	5	21	1	5	14	**270**

Table 7. Primary Supports OAA Active Providers Enrolled Across Service Categories

OAA Providers by Caregiver Service Provided	OAA Respite (includes companion-like services) Providers	OAA Caregiver Coaching and Counseling Providers	OAA Caregiver Training and Education Providers	OAA Homemaker Providers
Respite (includes companion-like services)	**37**	36	13	14
Coaching and Counseling	36	**53**	17	18
Training and Education	13	17	**18**	4
Homemaker	14	18	4	**29**

Table 8. Secondary Supports OAA Active Providers Enrolled Across Service Categories

OAA Providers by Caregiver Service Provided	OAA Chore Providers	OAA Environmental Adaptation Providers	OAA Transportation Providers
Chore	**27**	3	18
Environmental Adaptation	3	**5**	3
Transportation	18	3	**35**

Tables 6−8 offer a similar profile of OAA providers. Notably, significant provider overlap is evident within the caregiver coaching and counseling group across the other primary support categories. This high amount of service provision overlap is favorable should DHS seek to cultivate additional caregiver consultant workforce.

Network Element: Provider Continuity Across Programs

Understanding provider enrollment patterns is another factor HMA considered related to access, utilization, and opportunity. It was generally believed that high provider continuity was evident across OAA and AC/EW programs. Provider continuity provider network analyses are noted in Tables 9 and 10.

Table 9. Primary Caregiver Support Services: Continuity within Specific Service Category

Continuity of Primary Caregiver Supports Across All Programs	Number of OAA Providers ALSO in Active EW/AC Network	% of OAA Providers in Enrolled EW/AC Set that Are Also Active
Adult Day Services	1	100%
Caregiver Coaching and Counseling	33	94%
Caregiver Training and Education	12	100%
Homemaker	19	83%
Respite	21	91%

Table 10. Secondary Caregiver Support Services: Continuity within Specific Service Category

Continuity of Secondary Caregiver Supports Across All Programs	Number of OAA Providers ALSO in Active EW/AC Network	% of OAA Providers in Enrolled EW/AC Set That Are Also Active
Chore	18	81.8%
Environmental Adaptation	3	100%
Transportation	25	96.2%

HCBS Provider Network Navigation Resources

Network Element	AC Navigation Resources	EW Navigation Resources	OAA Navigation Resources
Tools used to locate HCBS providers	Counties leverage the MHCP Provider Directory as well as MinnesotaHelp.info	MCOs told to use MinnesotaHelp.info first but may also have other resources from receiving the DHS PECD file monthly	Each AAA contracts for their own HCBS provider network. Information is found on AAA webpages and on MinnesotaHelp.info

Case managers, care coordinators, and caregiver consultants supporting individuals who interface with AC, EW, and OAA programs must have accurate information to make effective and timely referrals to increase the likelihood that caregivers will accept services. In OAA programs, the caregiver consultant is the primary navigator of caregiver supports. Caregiver consultants have access to the caregiver education and support platform that Minnesota has developed to house many caregivers support resources. In addition, caregiver consultants can leverage information available on MinnesotaHelp.info and are expected to be experts with local community resources.

In AC and EW programs, case managers and care coordinators rely on provider information from MN DHS provider enrollment and MinnesotaHelp.info. Throughout our research for this project, HMA identified inconsistencies in these data sources. It also appears that EW care coordinators and AC case managers have been directed to use outdated provider network resources. This situation presents an increased risk of referral complications, caregiver dissatisfaction, and an inability to connect caregivers with appropriate supports. It also generates additional administrative work. Moreover, AC case managers and EW care coordinators are unable to access the caregiver education and support platform that OAA uses because this resource is available on a limited basis in the state. Increasingly, EW MCOs are offering supplemental benefits that support caregivers. Primarily only MCO care coordinators are aware of these benefits, and they are not promoted across other key navigation entities that connect caregivers to supports.

MINNESOTA HCBS UTILIZATION AND POPULATION DEMOGRAPHICS

MN HCBS & Caregiver Population

Demographics

According to AARP and the National Alliance for Caregiving, 61 percent of today's family caregivers are women and 39 percent are men, with an average age of 49 years old. They span multiple generations, with 6 percent from Gen-Z, 23 percent are Millennials, 29 percent are Gen-X, 34 percent are Baby Boomers, and 7 percent are of the Silent generation. Most caregivers provide support for relatives, with the greatest percentage (50%) caring for a parent or in-law.[14]

The study data allow a description of the population of older adults receiving services that include people who have family caregivers and individuals who do not. We observe variation in the demographics between participants in the AC program, EW, and OAA HCBS services discussed in this study. One unique aspect of the report is that it identifies variation in demographics and service use among program participants with and without family caregivers. This view can potentially identify opportunities for programmatic and policy changes to better tailor the service system to the distinct needs of subpopulations of older adults needing HCBS.

Going beyond a binary definition of with or without the presence of a family caregiver and to differentiate the various levels of caregiver involvement, HMA created caregiver tiers that were applied across AC, EW, and OAA data. The members served by these three programs were categorized into one of four mutually exclusive categories:

- **Supported caregiver:** Defined as members receiving registered Title III E services (OAA) or caregiver training and education services (EW/AC)
- **Identified caregiver:** Members with an identified caregiver per their program-specific assessment form (AC/EW assessment tools and the presence of a caregiver ID in the OAA data)
- **Presumed caregiver:** Members with a spouse or living with someone
- **No caregiver:** Members who, per their assessment

data, do not have any connection to a potential informal caregiver

Categories are applied hierarchically, meaning members will be placed in the first classification for which they meet the criteria. As an example, members of the identified caregiver category are identified caregivers who are not receiving supports, whereas presumed caregivers are informal caregivers who are not identified as a caregiver per the assessment form and do not receive supports.

Over the study period, state fiscal years (SFYs) 2017−2021, the number of identified caregivers in AC and EW programs increased significantly. One might anticipate a corresponding increase in AC and EW supported caregivers during this study period as well, but this trend was not observed. The significant uptick in identified caregivers is worthy of further contemplation and research into the cause (e.g., data entry changes, assessment training, system changes) of the observed trend. Of note, the OAA identified caregiver trend decreased during the study period; however, as previously discussed in this report, the caregiver identification and engagement processes between AC/EW and OAA programs are quite different.

Over the study period, SFYs 2017−2021, the number of supported caregivers and identified caregivers increased, whereas the number of presumed caregivers and no caregiver categories in EW and AC declined. With registered Title III E OAA services, the opposite pattern is largely observable, with a decrease in the unduplicated care recipients in the supported caregiver and identified caregiver categories and an increase in the presumed caregiver category. However, it is a positive sign that the no caregiver category for the OAA care recipients declined.

Table 10 displays the unique care recipient count for the first and last year of study data by program and level of caregiver involvement.

Table 10. Unique Care Recipient Count by Program and Caregiver Status, SFYs 2017 and 2021

Population	EW Unique Caregiver Count and Status SFY 2017	EW Unique Caregiver Count and Status SFY 2021
Supported Caregiver	103	105
Identified Caregiver	625	11,436
Presumed Caregiver	25,507	14,688
No Caregiver	11,387	9,020

Population	AC Unique Caregiver Count and Status SFY 2017	AC Unique Caregiver Count and Status SFY 2021
Supported Caregiver	35	43
Identified Caregiver	28	2,011
Presumed Caregiver	2,683	805
No Caregiver	1,152	837

Population	OAA Unique Caregiver Count and Status SFY 2017	OAA Unique Caregiver Count and Status SFY 2021
Supported Caregiver	3,630	2,821
Identified Caregiver	1,288	764
Presumed Caregiver	22,776	18,539
No Caregiver	28,618	26,625

In some of the project data analysis, we used member months to assess experience and impact. Member months are traditionally used in actuarial calculations as a measure of risk exposure. Member months are preferred to the count of members because member months account for the duration of enrollment. Member months also reduce duplication issues, allowing for members who move or have other status changes to be reflected accurately in the count of member months by region, caregiver status, living arrangement, or other key variables.

As Figure 4 illustrates, during the study period of 2017−2021, across the three programs, there were approximately 1,265,792 member months (MMs), representing 38 percent of member months in which a service recipient was without access to an informal caregiver. Of the remaining 62 percent of member months (approximately 1,595,478) the service recipient had someone who could serve as a potential caregiver. Both the AC and EW programs had more member months with caregivers than without—73 percent and 72 percent, respectively (see Figures 6 and 7).

Conversely, the OAA services have comparatively few months with an identified caregiver (6%) but have a much higher portion of members receiving caregiver support services (see Figure 5)—4.2 percent versus 0.3 percent for EW and 1.1 percent for AC.

Figure 4. Member Months of Care Recipients by Caregiver Status by Program, SFYs 2017–2021

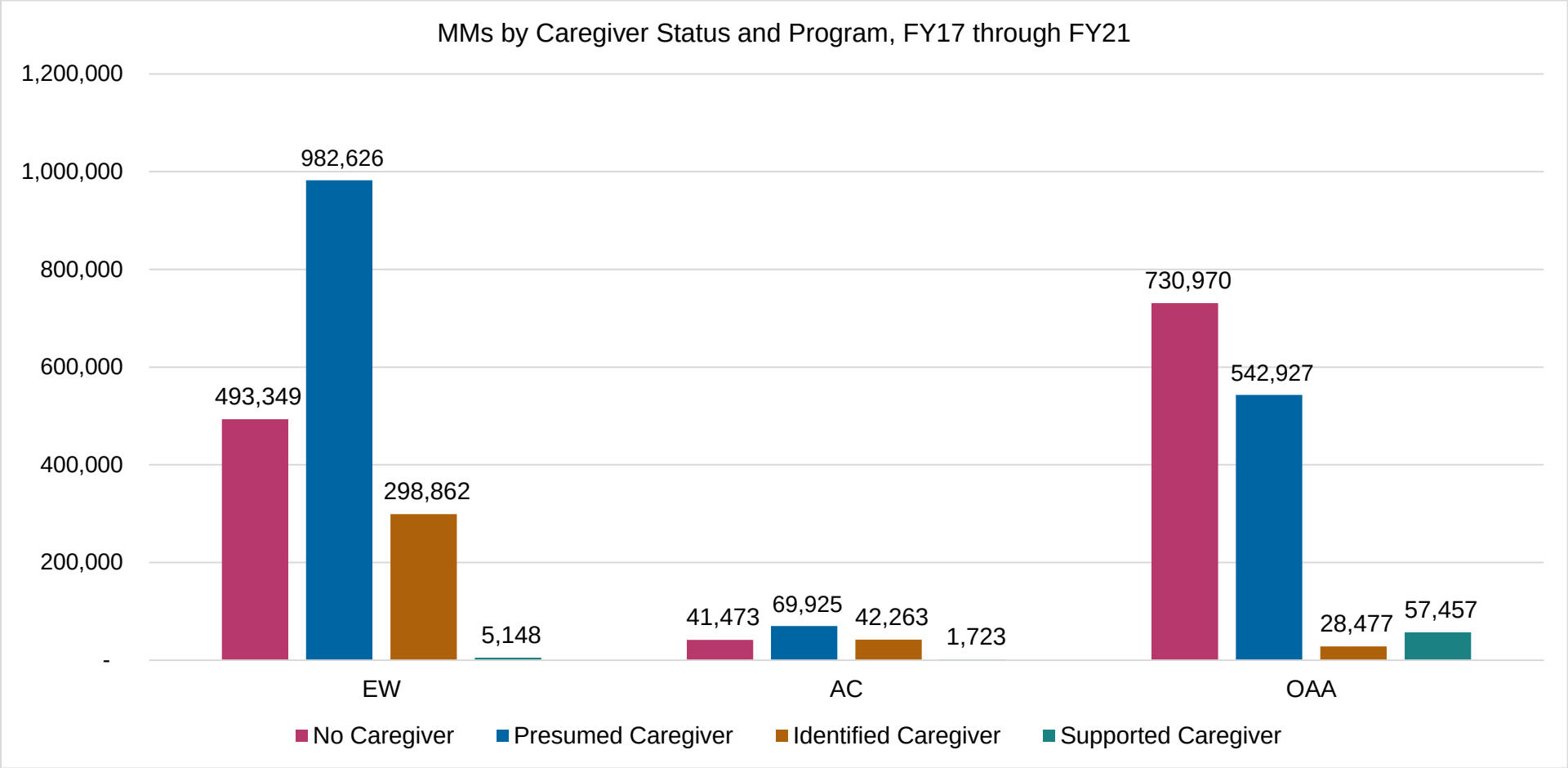
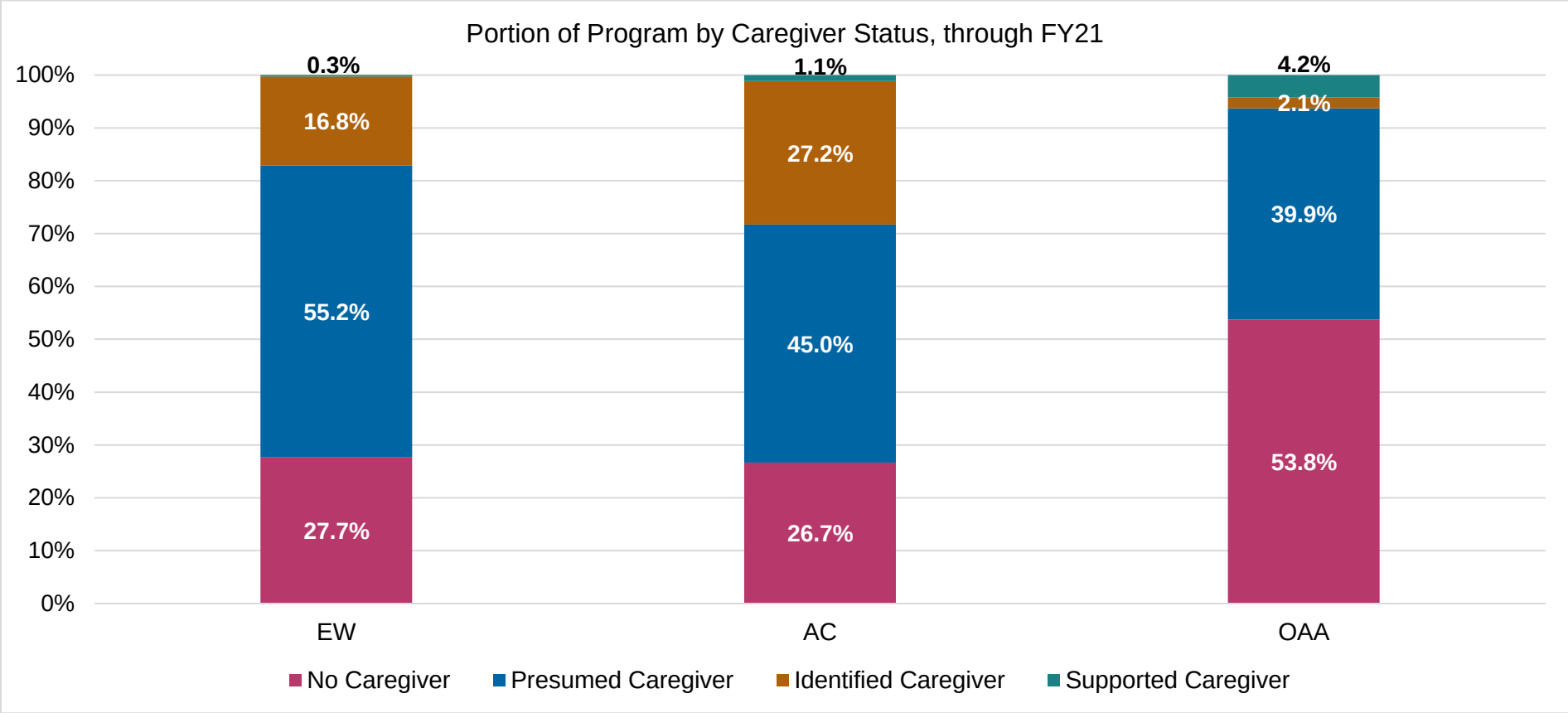


Figure 5. Portion of Program Participants by Caregiver Status, SFYs 2017–2021



At the program level, the AC and EW programs have experienced an overall increase in member months with an identified caregiver across the study period, along with a decrease in months without caregiver presence. Figures 6 and 7 show that the pattern has not always been linear.

Of note, the demographic fields necessary to establish caregiver status are not available by year for the OAA data, therefore presenting caregiver status by year for OAA would be an invalid analysis approach; therefore, we have excluded OAA data from this portion of the report.

Figure 6. AC Member Months of Care Recipients by Presence of a Caregiver, SYFs 2017–2021

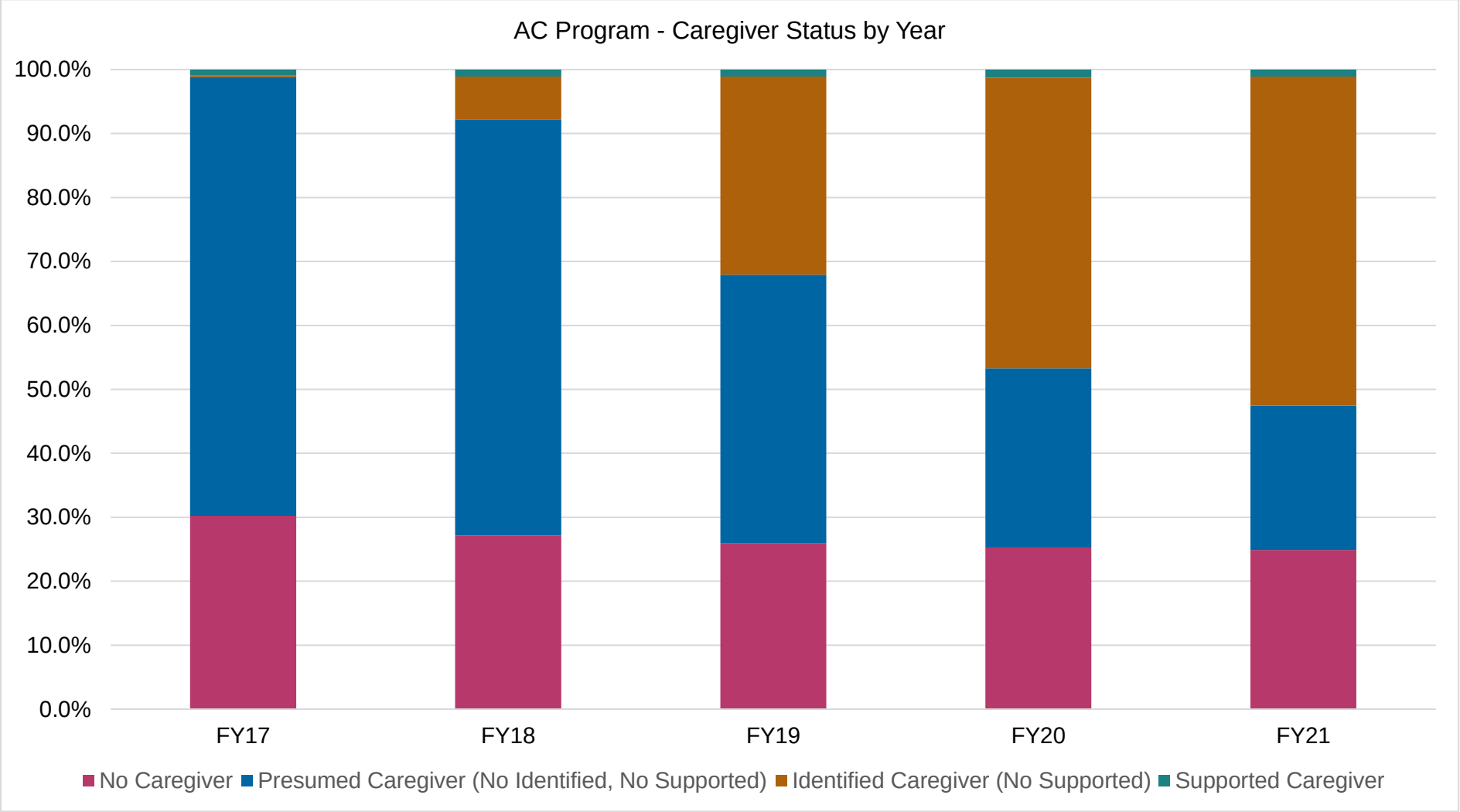
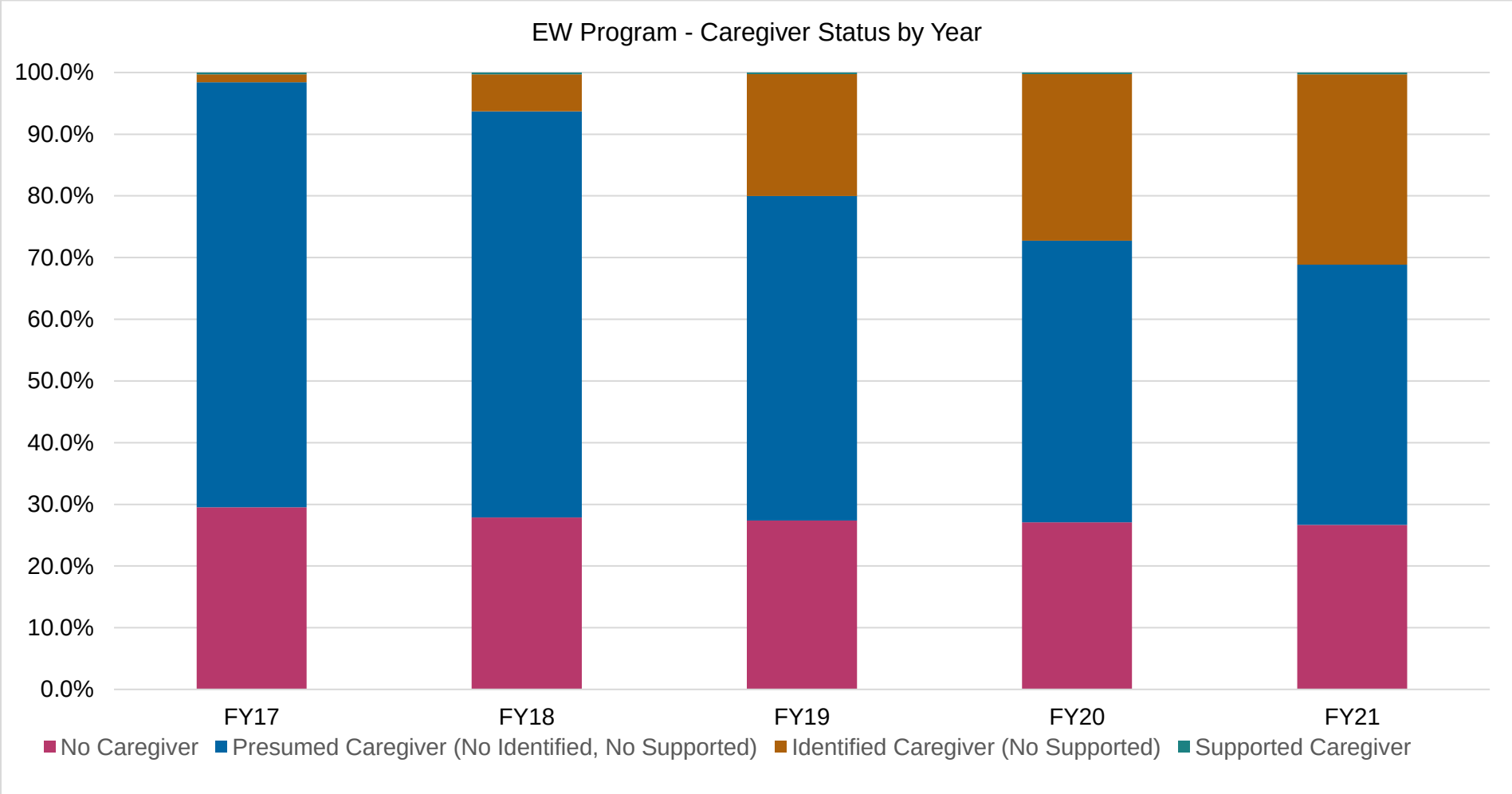


Figure 7. EW Caregiver Status by Year, SFYs 2017−2021



Racial and Ethnic Analyses

The study data identified 39 different languages that program participants spoke during the study period. Table 11 displays the top languages (anything at or above 0.1% of member/utilizer months). The top languages after English are Somalian, Hmong, Russian, and Vietnamese.

Table 11. Top Languages Spoken by Care Recipients, 2017–2021

Language of Care Receiver	Percentage of Member/Utilizer Months
English	86.1%
Somalian	3.6%
Hmong	2.6%
Russian	1.5%
Vietnamese	1.0%
Spanish	0.8%
Laotian	0.6%
Oromo	0.5%
Karen	0.4%
Khmer	0.4%
Mandarin	0.2%
Amharic	0.2%
Arabic	0.2%
Korean	0.2%
Burmese	0.2%
Cantonese	0.1%
Tigrinya	0.1%

The study data indicate variation in the percentage of member months by caregiver category among people of different races and ethnicities. These data present a new framework through which the state should consider disparities, incongruence in access, and opportunities to invest in efforts that impact variation in service trends across racial and ethnic communities enrolled in AC and EW programs.

Table 12 shows that the rankings of racial and ethnic categories in terms of caregiver categories that largely follow the size of each racial and ethnicity category among AC program participants. However, the Asian or Pacific Islander category tends to display a higher percentage of supported caregivers than to be expected in AC, but that observation is not present among EW program participants (see Table 13).

Broadly, over the study period, non-White racial/ethnic groups are growing across the caregiver categories, with a small decrease in the portions of White program participants across both AC and EW, with greater diversity among the participants in those two programs. The trend in diversification is across all age groups in Minnesota, and the state demographer projects people of color will exceed one-third of the total population in the next 20 to 30 years.[15]

Table 12. Percentage of Member Months by Caregiver Category, Race/Ethnicity for AC, and Year, SFYs 2017–2021

Caregiver Category	Race/Ethnicity	Percentage of AC Participant Caregivers in SFY 2017	Percentage of AC Participant Caregivers in SFY 2018	Percentage of AC Participant Caregivers in SFY 2019	Percentage of AC Participant Caregivers in SFY 2020	Percentage of AC Participant Caregivers in SFY 2021
Supported Caregiver	Native American or Alaskan Native	0.0%	0.0%	0.0%	0.0%	0.0%
	Black or African American	4.1%	4.2%	9.7%	0.0%	9.0%
	Hispanic	0.0%	0.0%	0.0%	0.0%	2.8%
	Unknown	15.3%	21.9%	16.8%	15.3%	9.6%
	White	76.6%	70.4%	72.6%	84.8%	75.2%
	Asian or Pacific Islander	4.1%	3.6%	0.9%	0.0%	3.4%
	Multiracial	0.0%	0.0%	0.0%	0.0%	0.0%
	Percentage of Total Member Months	**1.0%**	**1.1%**	**1.1%**	**1.3%**	**1.1%**
Identified Caregiver	Native American or Alaskan Native	0.0%	0.8%	0.8%	1.4%	1.2%
	Black or African American	10.8%	6.7%	6.2%	7.1%	7.1%
	Hispanic	0.0%	1.3%	1.4%	1.2%	1.2%
	Unknown	3.1%	9.8%	12.6%	12.4%	11.9%
	White	86.2%	80.7%	78.1%	76.9%	77.8%
	Asian or Pacific Islander	0.0%	0.4%	0.6%	0.8%	0.6%
	Multiracial	0.0%	0.3%	0.3%	0.2%	0.2%
	Percentage of Total Member Months	**0.2%**	**6.7%**	**31.0%**	**45.4%**	**51.4%**

Presumed Caregiver	Native American or Alaskan Native	1.0%	0.7%	0.8%	0.8%	1.3%
	Black or African American	5.0%	5.8%	5.7%	6.0%	6.1%
	Hispanic	1.0%	1.0%	1.3%	1.1%	1.1%
	Unknown	10.8%	11.5%	11.2%	10.7%	11.7%
	White	81.6%	80.1%	79.9%	80.2%	78.3%
	Asian or Pacific Islander	0.5%	0.7%	0.8%	0.9%	1.0%
	Multiracial	0.1%	0.2%	0.3%	0.3%	0.5%
	Percentage of Total Member Months	**68.6%**	**65.0%**	**41.9%**	**28.0%**	**22.6%**
No Caregiver	Native American or Alaskan Native	0.6%	0.7%	0.5%	0.5%	0.6%
	Black or African American	4.4%	3.9%	4.8%	5.4%	6.3%
	Hispanic	0.9%	0.8%	0.5%	0.4%	0.4%
	Unknown	6.9%	7.5%	7.4%	6.9%	7.2%
	White	86.9%	86.8%	86.5%	86.3%	85.0%
	Asian or Pacific Islander	0.2%	0.3%	0.3%	0.3%	0.4%
	Multiracial	0.2%	0.0%	0.0%	0.1%	0.1%
	Percentage of Total Member Months	**30.2%**	**27.2%**	**26.0%**	**25.3%**	**24.9%**

Table 13. Percentage of Member Months by Caregiver Category, by Race/Ethnicity for EW by Year, SFYs 2017–2021

Caregiver Category	Race/Ethnicity	Percentage of MMs for EW Participant Caregivers in SFY 2017	Percentage of MMs for EW Participant Caregivers in SFY 2018	Percentage of MMs for EW Participant Caregivers in SFY 2019	Percentage of MMs for EW Participant Caregivers in SFY 2020	Percentage of MMs for EW Participant Caregivers in SFY 2021
Supported Caregiver	Native American or Alaskan Native	2.3%	0.0%	0.7%	2.5%	5.6%
	Black or African American	0.0%	1.7%	3.1%	1.2%	4.6%
	Hispanic	3.1%	1.1%	2.9%	4.5%	3.3%
	Unknown	0.0%	1.1%	1.1%	3.2%	4.3%
	White	92.4%	94.6%	89.7%	86.1%	76.9%
	Asian or Pacific Islander	2.3%	1.5%	2.6%	2.5%	4.5%
	Multiracial	0.0%	0.0%	0.0%	0.0%	1.0%
	Percentage of Total Member Months	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**0.3%**
Identified Caregiver	Native American or Alaskan Native	1.4%	1.6%	1.3%	1.2%	1.2%
	Black or African American	15.8%	18.1%	16.8%	16.7%	17.1%
	Hispanic	2.5%	3.5%	2.7%	2.5%	2.7%
	Unknown	1.8%	2.1%	2.6%	2.7%	2.8%

	White	60.7%	55.1%	59.8%	60.2%	59.6%
	Asian or Pacific Islander	17.8%	19.3%	16.6%	16.4%	16.4%
	Multiracial	0.1%	0.2%	0.2%	0.2%	0.2%
	Percentage of Total Member Months	**1.3%**	**1.3%**	**19.8%**	**27.0%**	**30.8%**
Presumed Caregiver	Native American or Alaskan Native	1.4%	1.3%	1.3%	1.3%	1.3%
	Black or African American	15.8%	15.7%	15.7%	15.7%	16.2%
	Hispanic	2.5%	2.5%	2.5%	2.6%	2.4%
	Unknown	1.8%	1.9%	1.8%	1.9%	1.8%
	White	60.7%	61.3%	61.5%	61.4%	61.2%
	Asian or Pacific Islander	17.8%	17.2%	17.2%	17.0%	17.0%
	Multiracial	0.1%	0.1%	0.1%	0.1%	0.1%
	Percentage of Total Member Months	**68.9%**	**68.9%**	**52.6%**	**45.6%**	**42.2%**
No Caregiver	Native American or Alaskan Native	1.5%	1.6%	1.7%	2.0%	2.0%
	Black or African American	13.1%	13.6%	13.7%	13.9%	14.7%
	Hispanic	1.3%	1.5%	1.7%	1.7%	1.9%
	Unknown	1.2%	1.2%	1.3%	1.3%	1.5%

	White	79.8%	78.9%	78.0%	77.5%	76.3%
	Asian or Pacific Islander	2.9%	3.2%	3.5%	3.5%	3.5%
	Multiracial	0.1%	0.1%	0.1%	0.2%	0.2%
	Percentage of Total Member Months	**29.5%**	**29.5%**	**27.4%**	**27.1%**	**26.7%**

The OAA demographic data are less precise than the AC and EW demographic data; therefore, the OAA data should be interpreted with an understanding that the data are less accurate than the AC and EW data. For racial and ethnic categories, the OAA data contain overlapping categories that are not mutually exclusive, for example: White, White non-Hispanic, and White Hispanic.

Broadly, as with AC and EW, the largest category is White, followed by Asian and then Black or African American. Other categories captured include Native American/Alaska Native, Native Hawai'ian/Other Pacific Islander, and multi-racial. Little variation is evident within race/ethnicity categories, with the exception that the percentage of utilizer months with no caregivers for the Asian category is less than either of the other caregiver categories. See the "Data Used for the Project" section of this report regarding data limitations.

Sex

More women than men participate in the three programs. This trend is expected to continue as noted in the Minnesota State Demographic Center's most recent long-term population projects report, which states that "females are likely to outnumber males by more than 50 percent in 2053."[16] As displayed in Figures 8−10, female participants in AC and EW are more than twice as prevalent as males, and 67 percent more prevalent in OAA services. Common across the programs and sexes is that presumed caregiver is the largest category, with one exception being no caregivers in OAA services outpacing presumed caregivers for women.

Figure 8. Unique AC Program Participants by Caregiver Category and Sex, SFYs 2017 and 2021

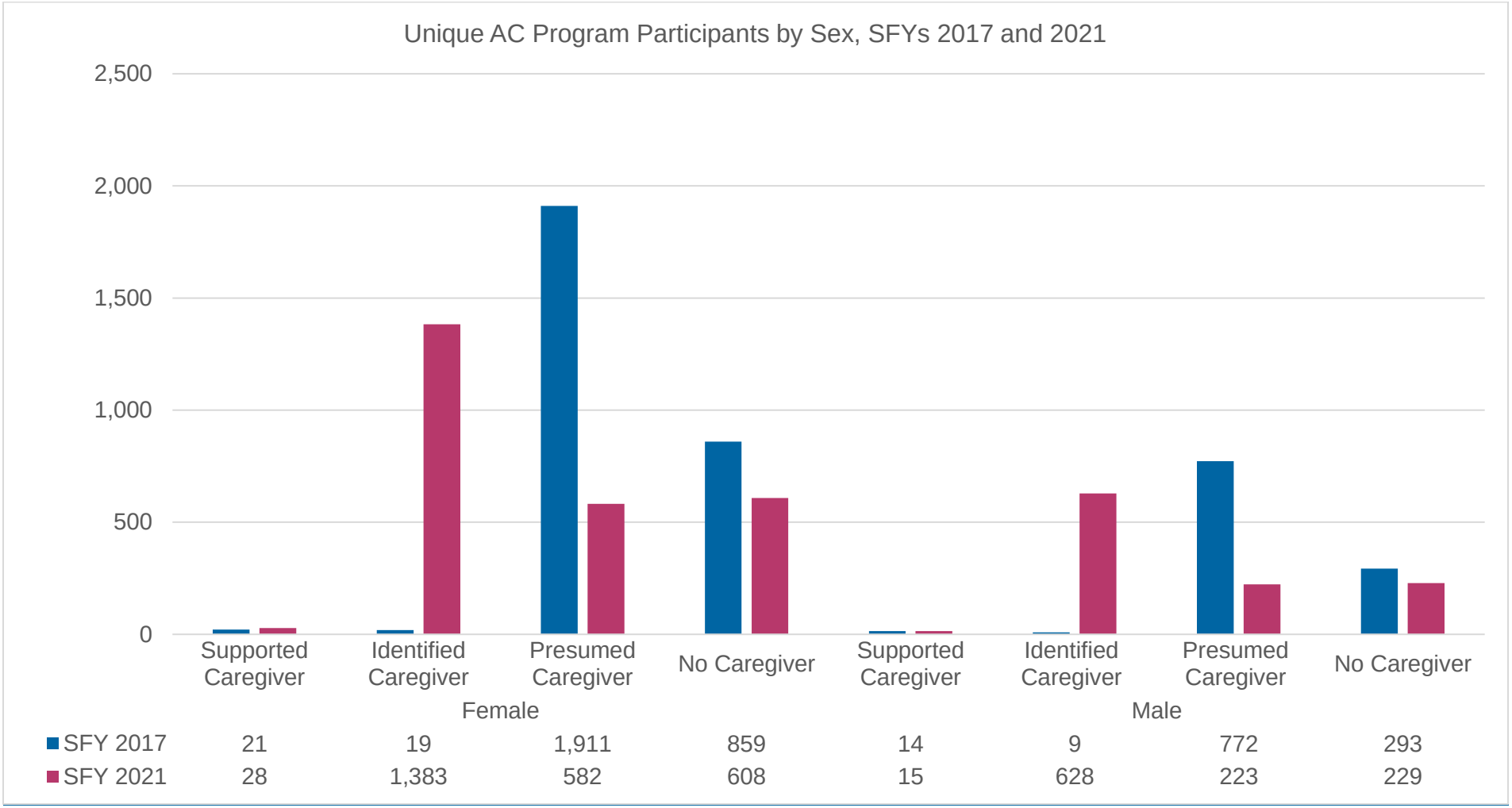


Figure 9. Unique EW Program Participants by Caregiver Category and Sex, SFYs 2017 and 2021

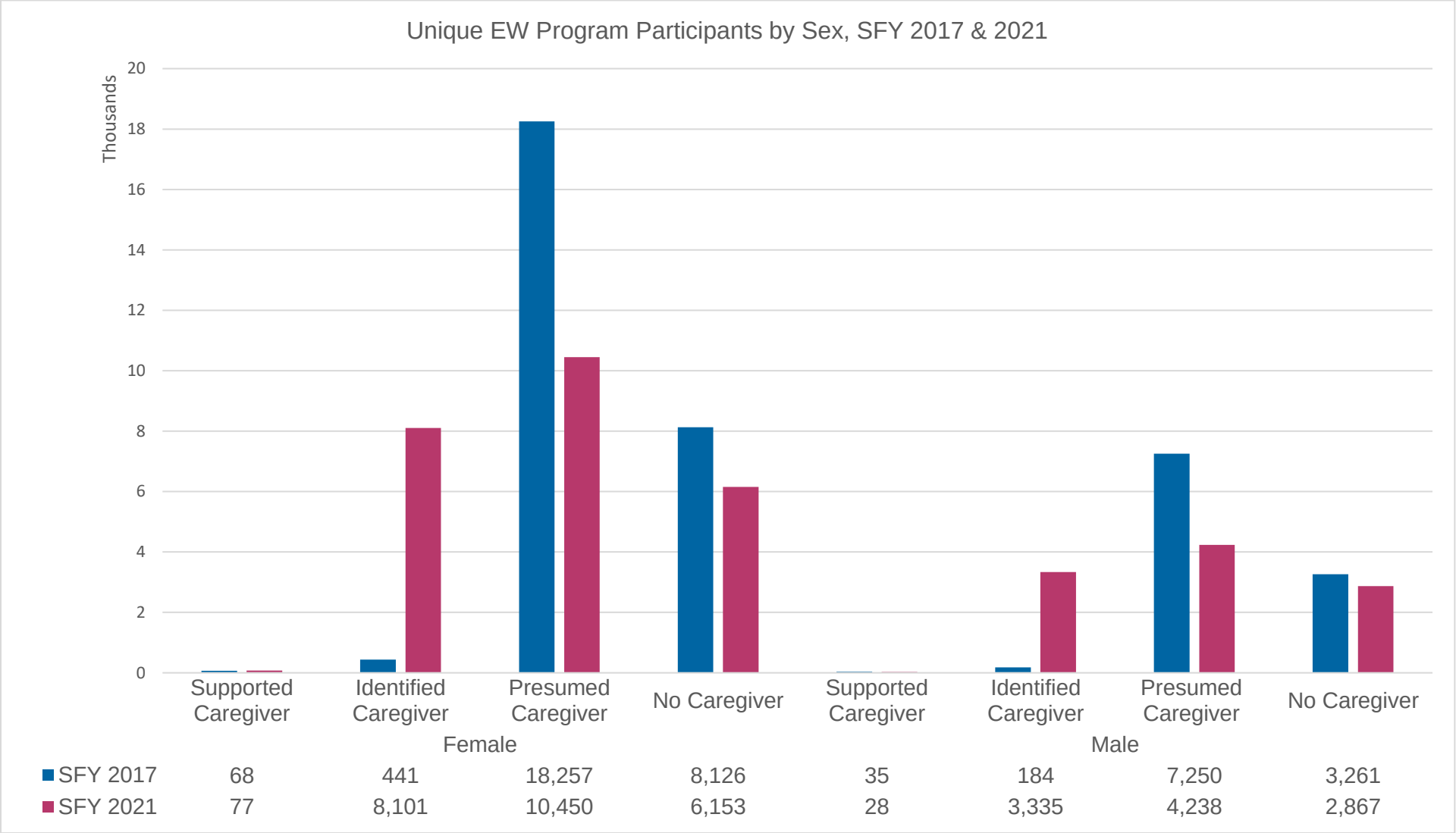
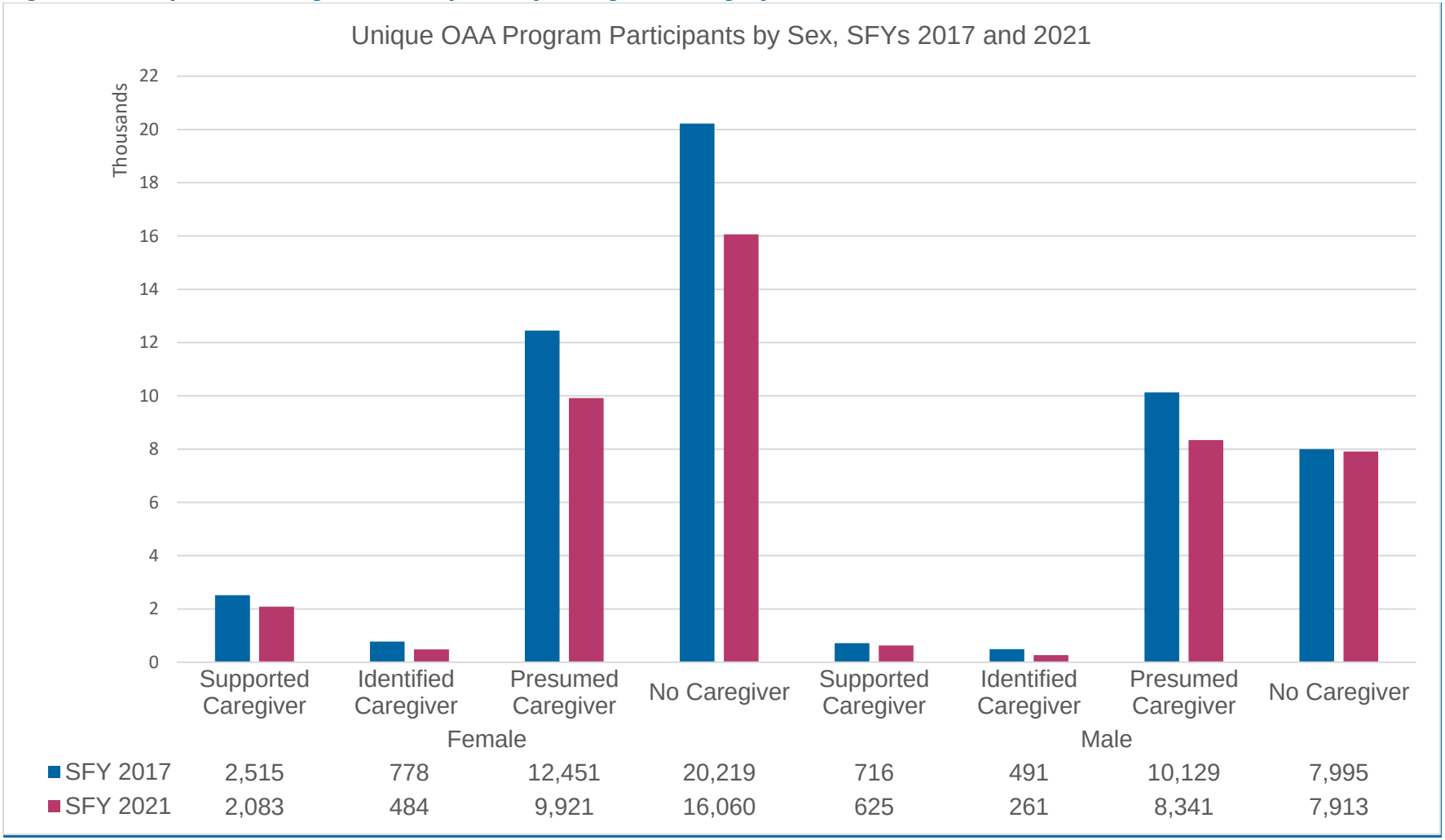


Figure 10. Unique OAA Program Participants by Caregiver Category and Sex, SFYs 2017 and 2021



Age

It is commonly understood that Minnesota's population is aging, and that trend among program participants is illustrated in Figures 11−13. In 2021, people in the 75−84-year-old age range consistently ranked as the largest group. In an unexpected trend, OAA program participants ages 85 and older declined from 2017 to 2021.

Figure 11. Unique AC Program Participants by Caregiver Category and Age Group, SFYs 2017 and 2021

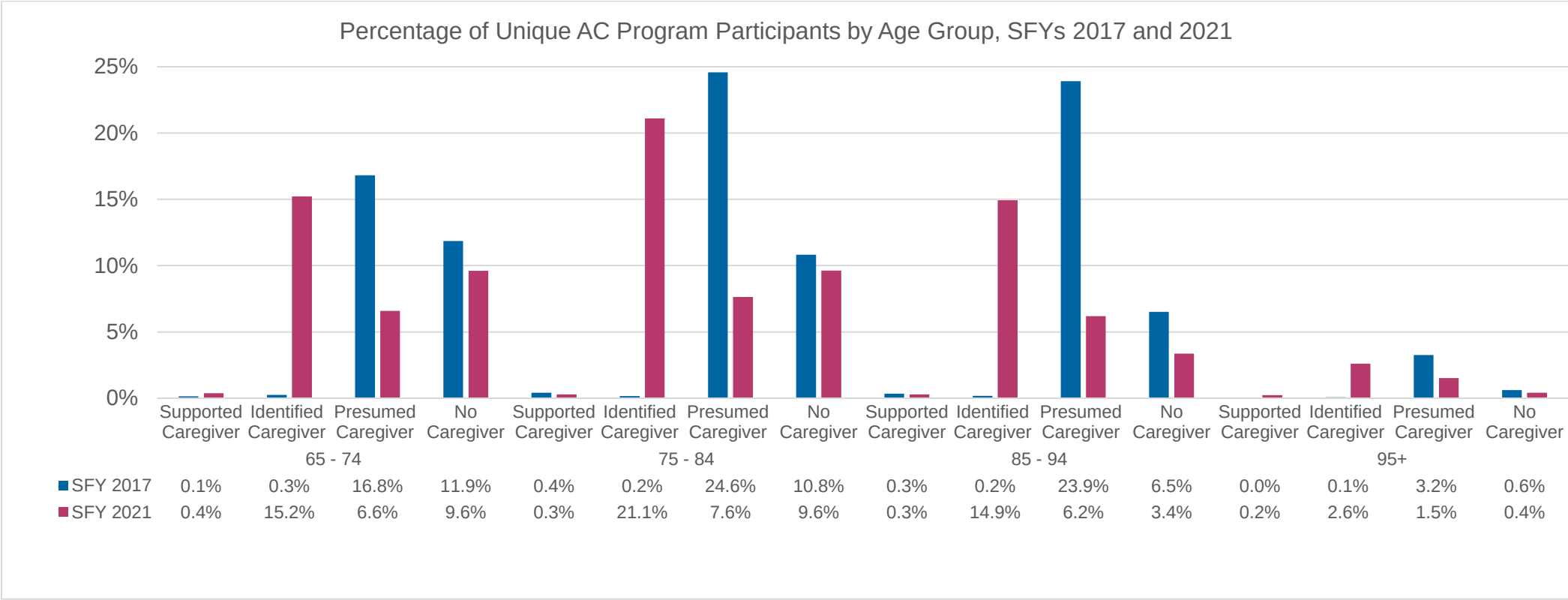


Figure 12. Unique EW Program Participants by Caregiver Category and Age Group, SFYs 2017 and 2021

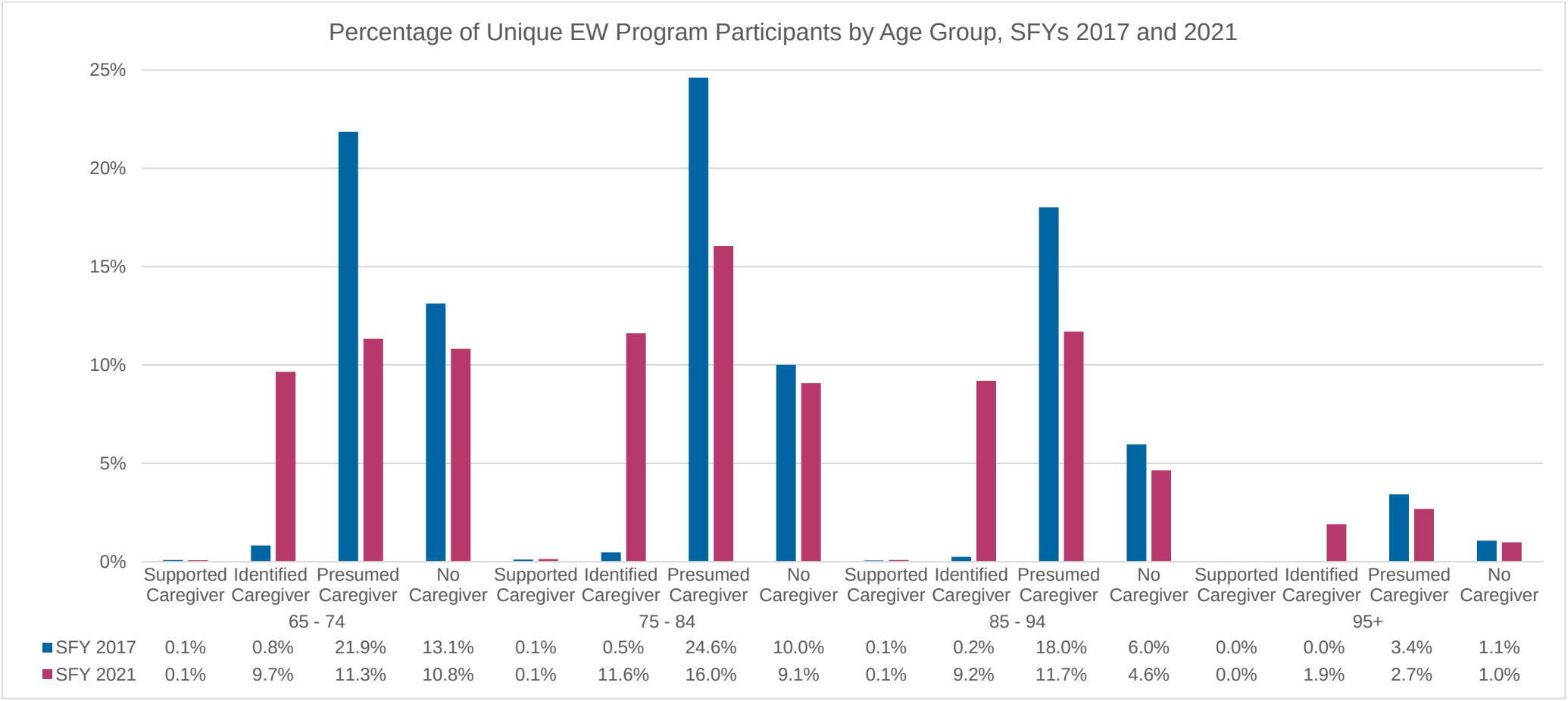
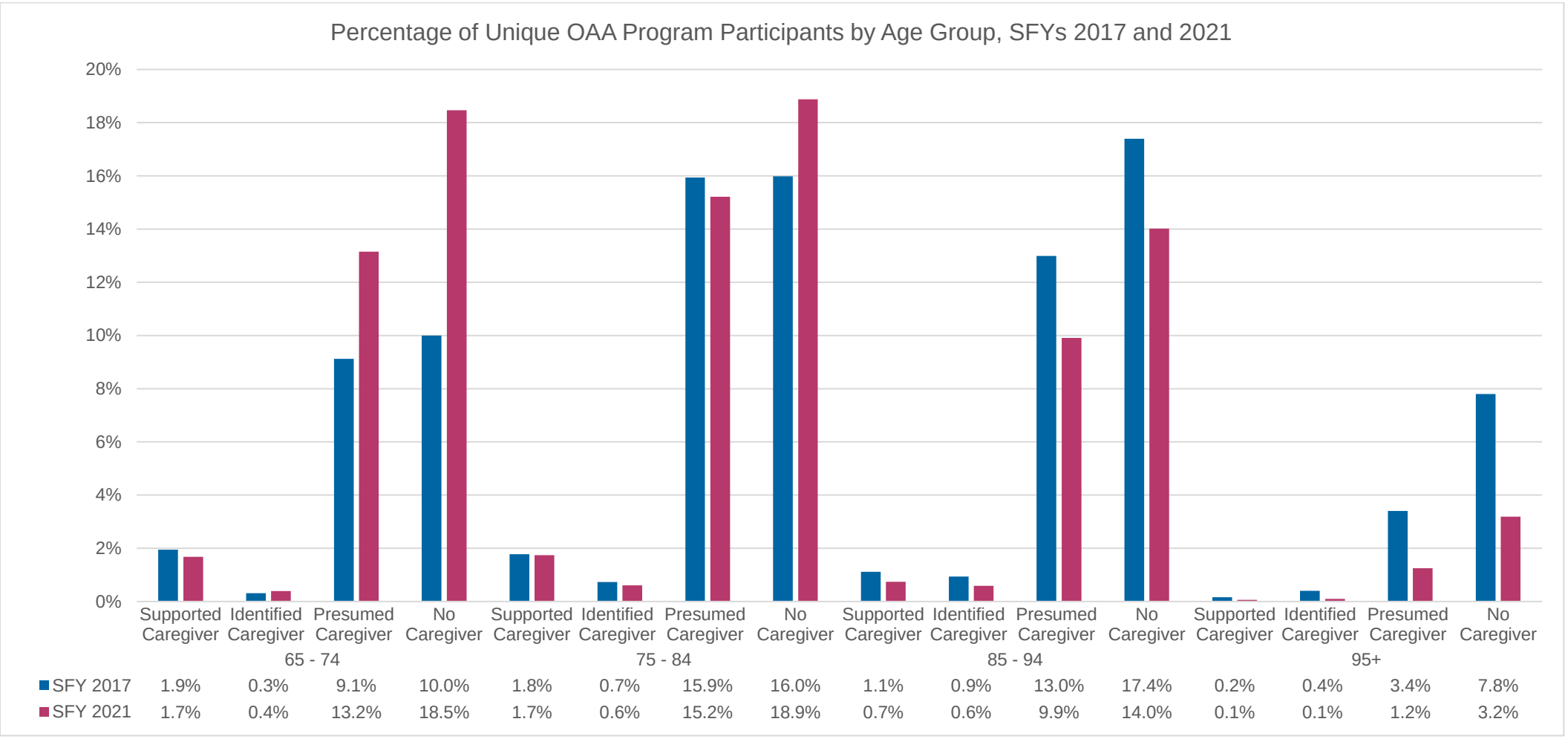


Figure 13. Unique OAA Program Participants by Caregiver Category and Age Group, SFYs 2017 and 2021



Region

The differences in terms of relative size of program participants by geographic regions (i.e., metro, urban, and rural) are displayed in Figures 14−16. It is worth noting the large number of rural Minnesotans who receive OAA services. Almost three times as many rural residents participate than urban dwellers, and more than twice as many rural than metro residents engage in OAA services.

Figure 14. Unique AC Program Participants by Caregiver Category and Region, SFYs 2017 and 2021

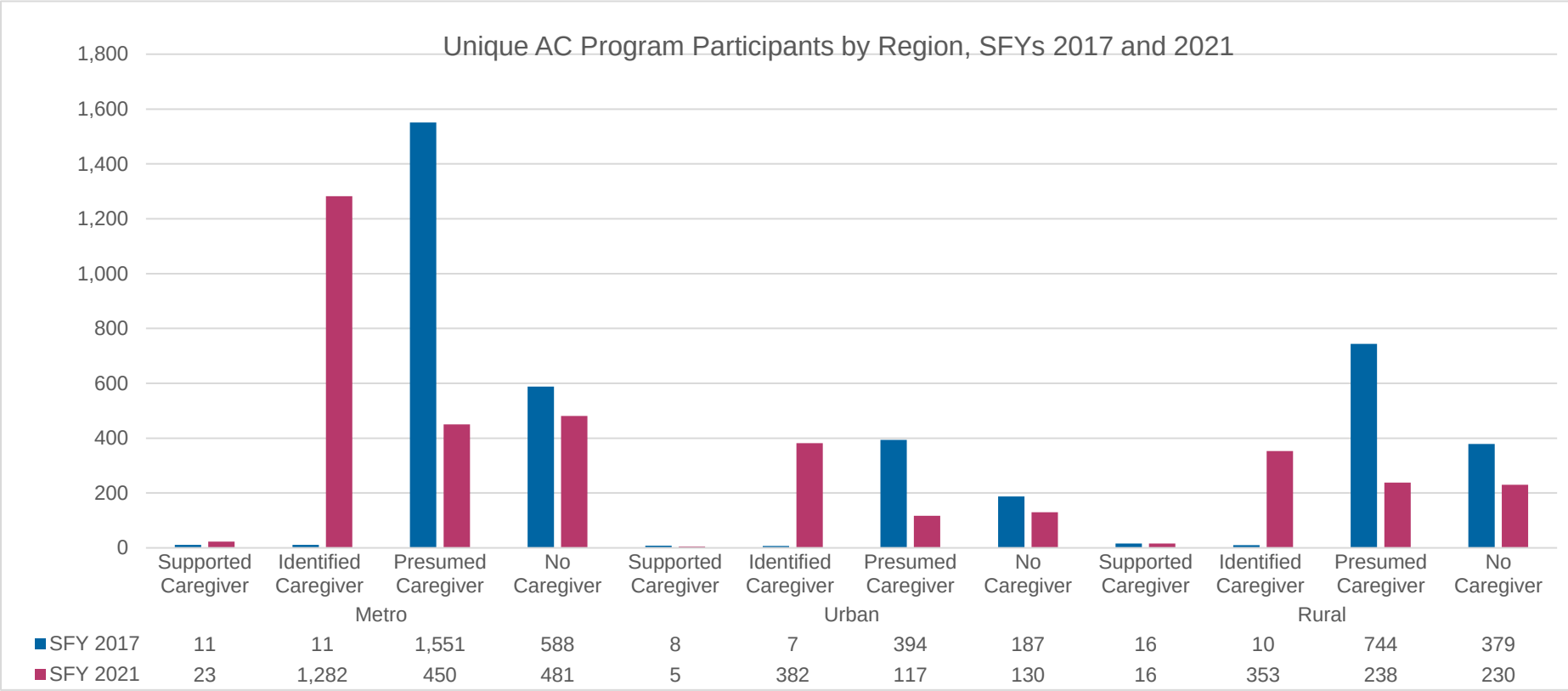


Figure 15. Unique EW Program Participants by Caregiver Category and Region, SFYs 2017 and 2021

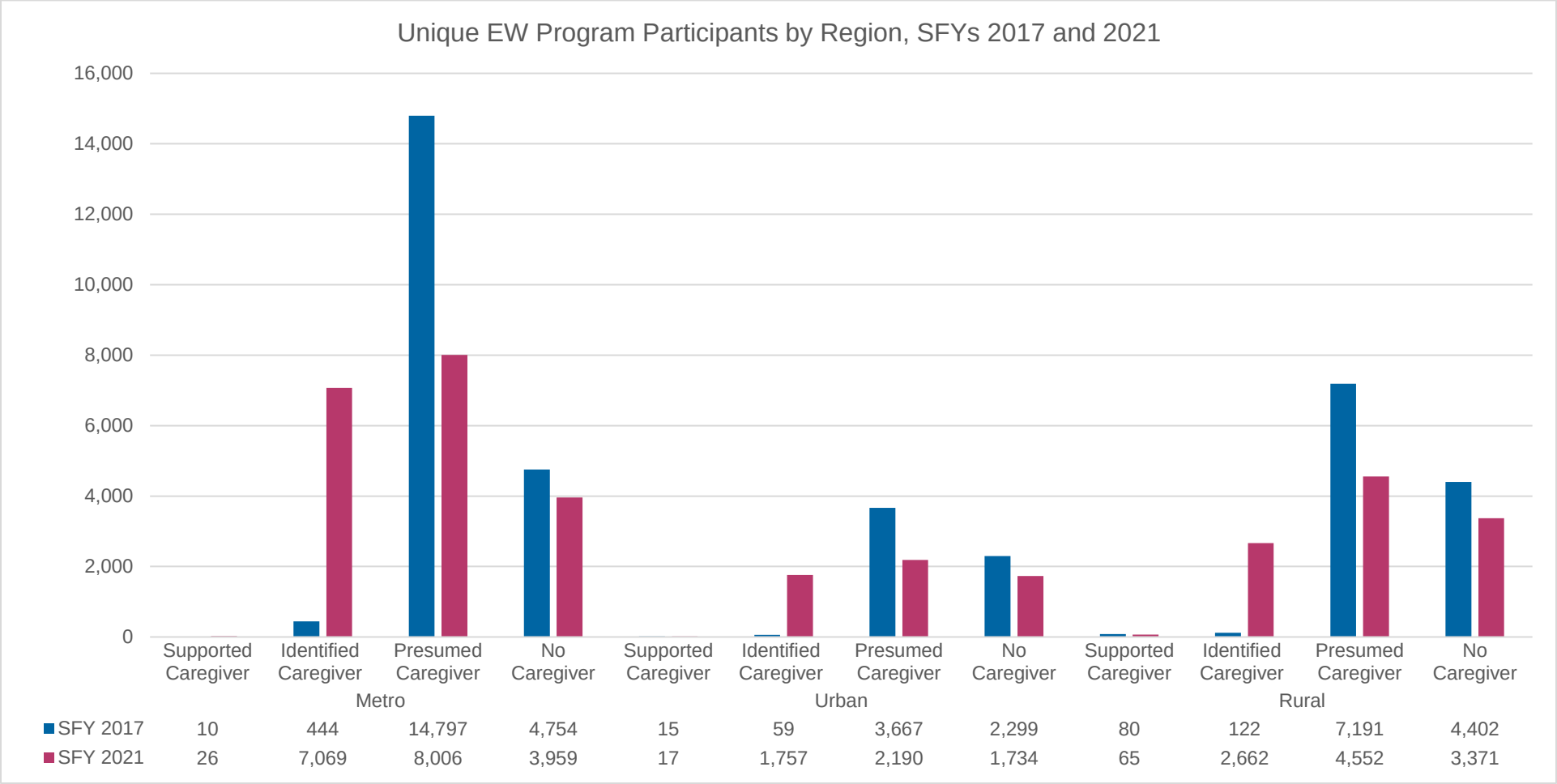
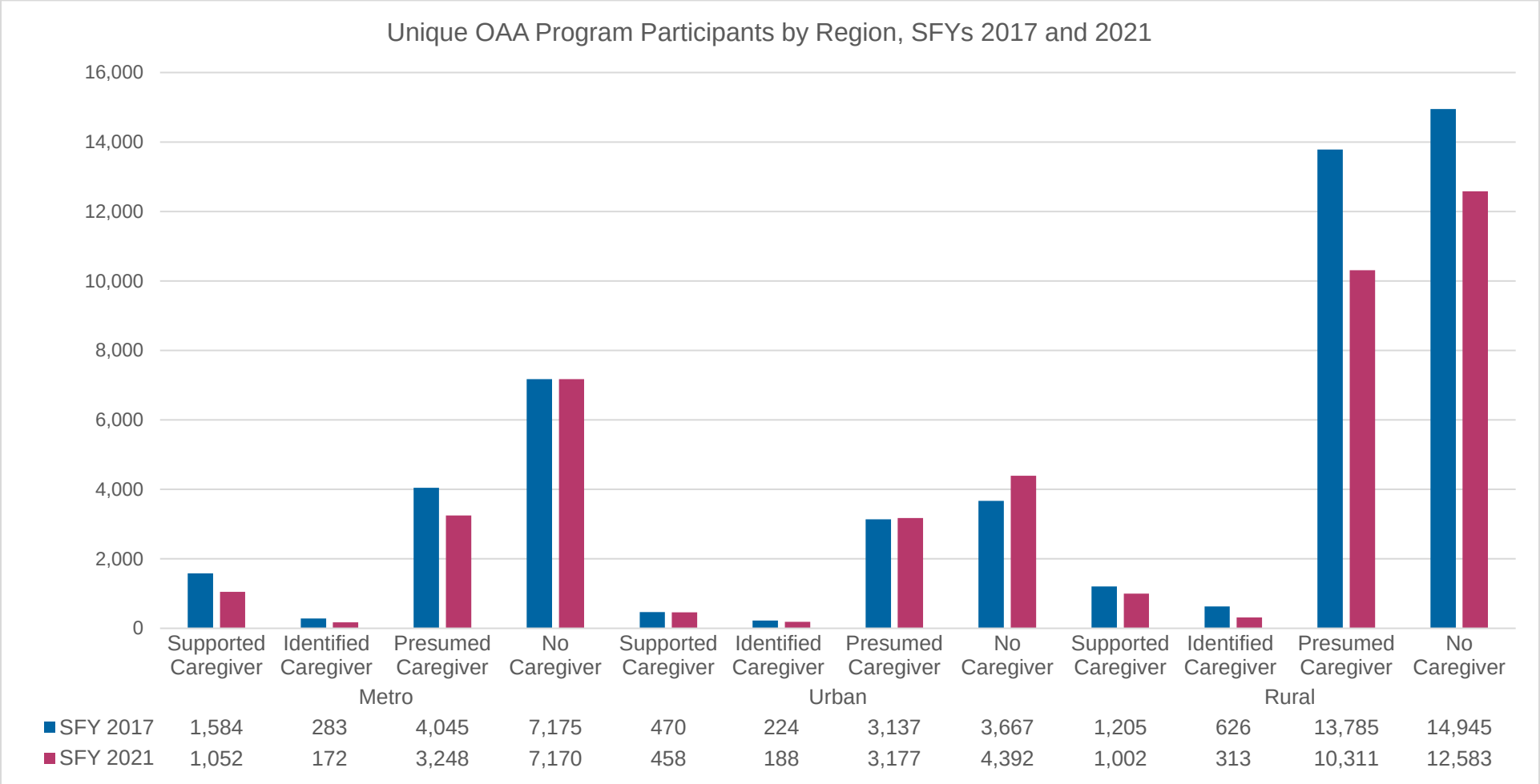


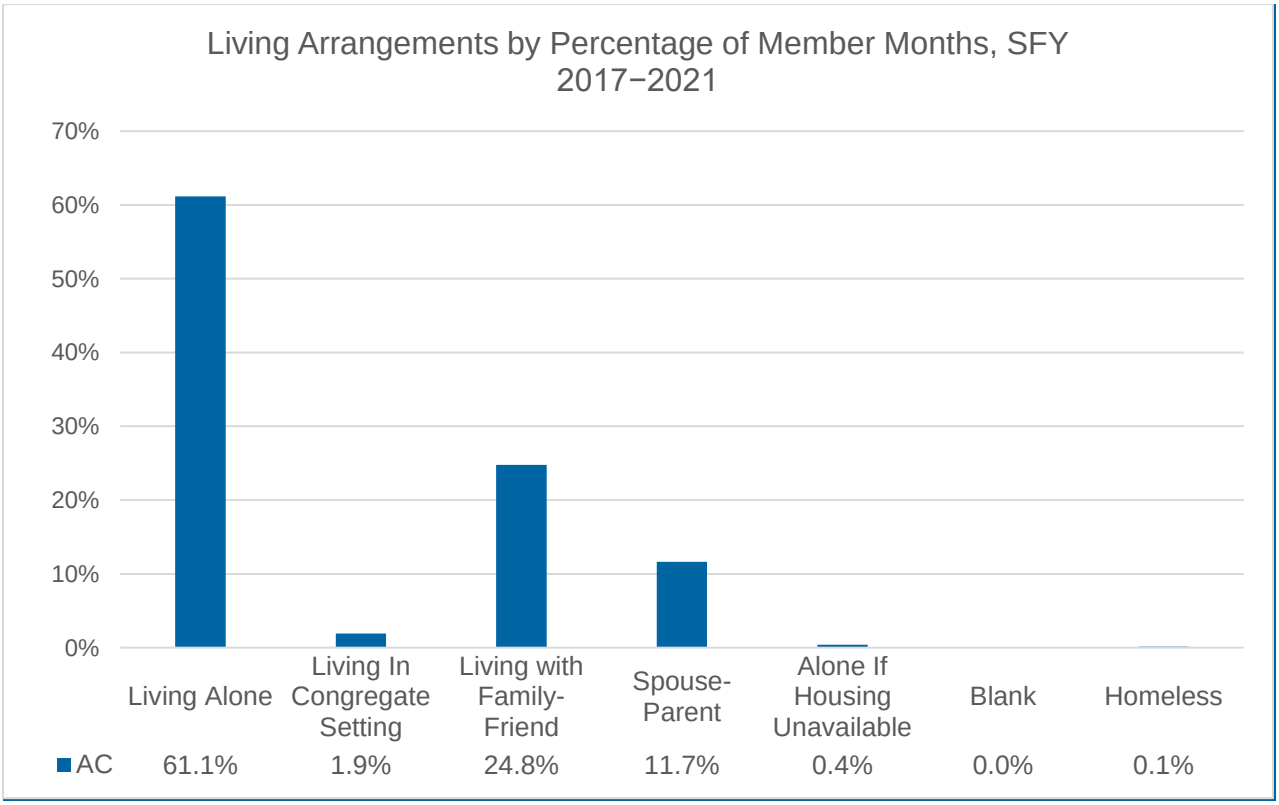
Figure 16. Unique OAA Program Participants by Caregiver Category and Region, SFYs 2017 and 2021



Living Arrangements

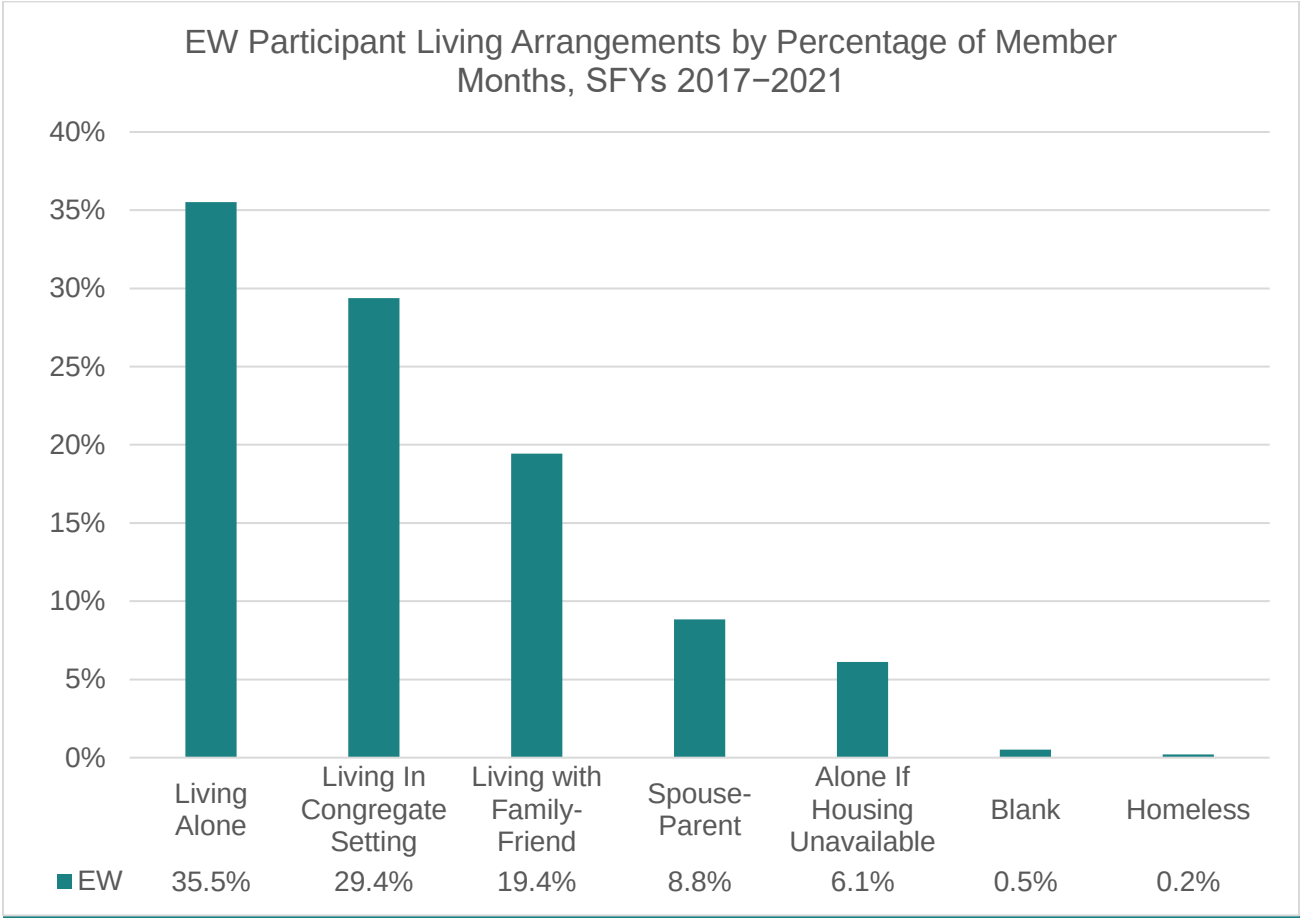
There is observable variation in the living arrangements across programs. Among AC program participants, living alone is the most common living arrangement; however, more than one-third of participants live with family, including spouses or parents, or friends (see Figure 17).

Figure 17. AC Participant Living Arrangements, SFYs 2017−2021



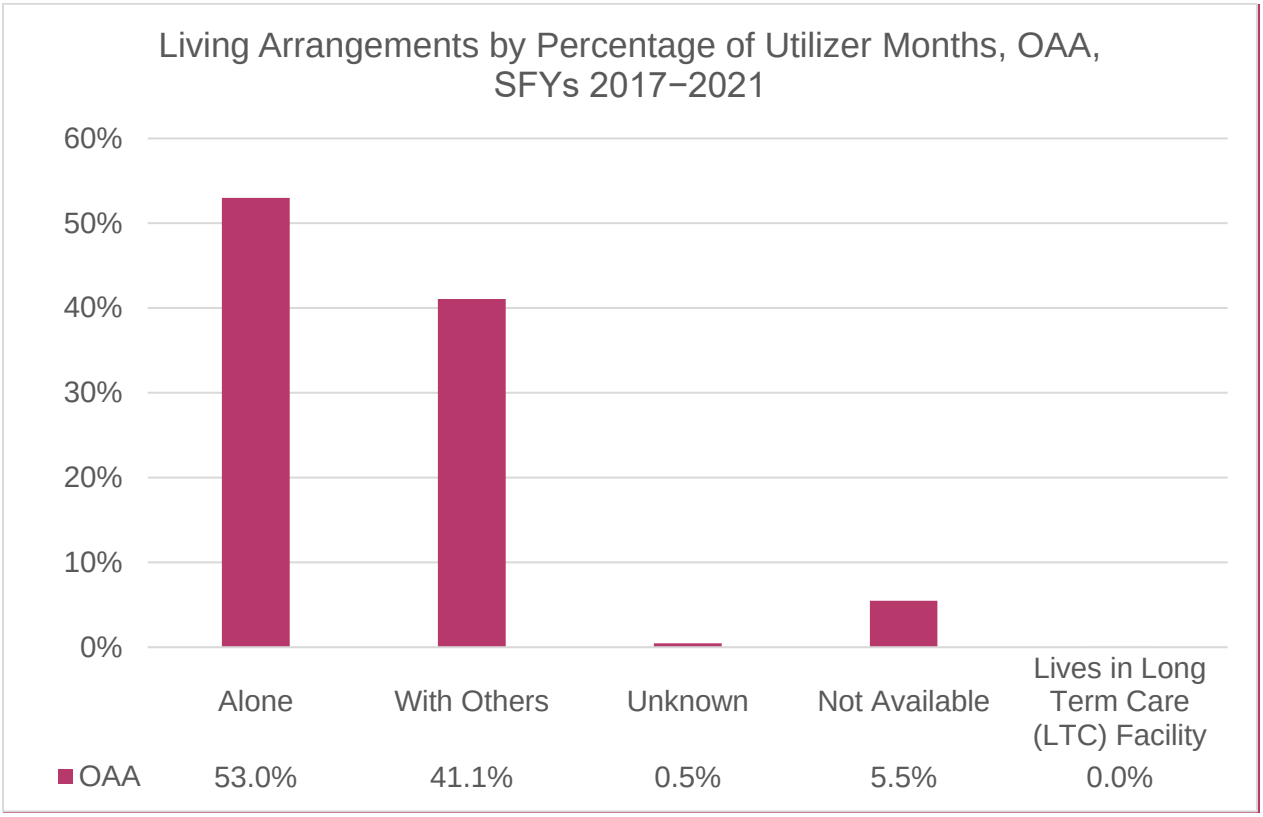
EW participants spent fewer member months living alone than AC participants, with a much higher portion (nearly 30%) in congregate settings (see Figure 18). This variation may be expected to some degree given the fact that EW covers customized living service and AC does not. In addition, fewer EW than AC participants live with family and friends.

Figure 18. EW Participant Living Arrangements, SFYs 2017−2021



Fewer categories of living arrangements are available within the OAA program data. Comparative data show that the percentage of OAA program participants who live alone falls between the percentages for AC and EW participants (see Figure 19). It is unsurprising that fewer OAA program participants live in long-term care facilities than their EW and AC counterparts given that Medicaid is the largest single payer of nursing facility care.

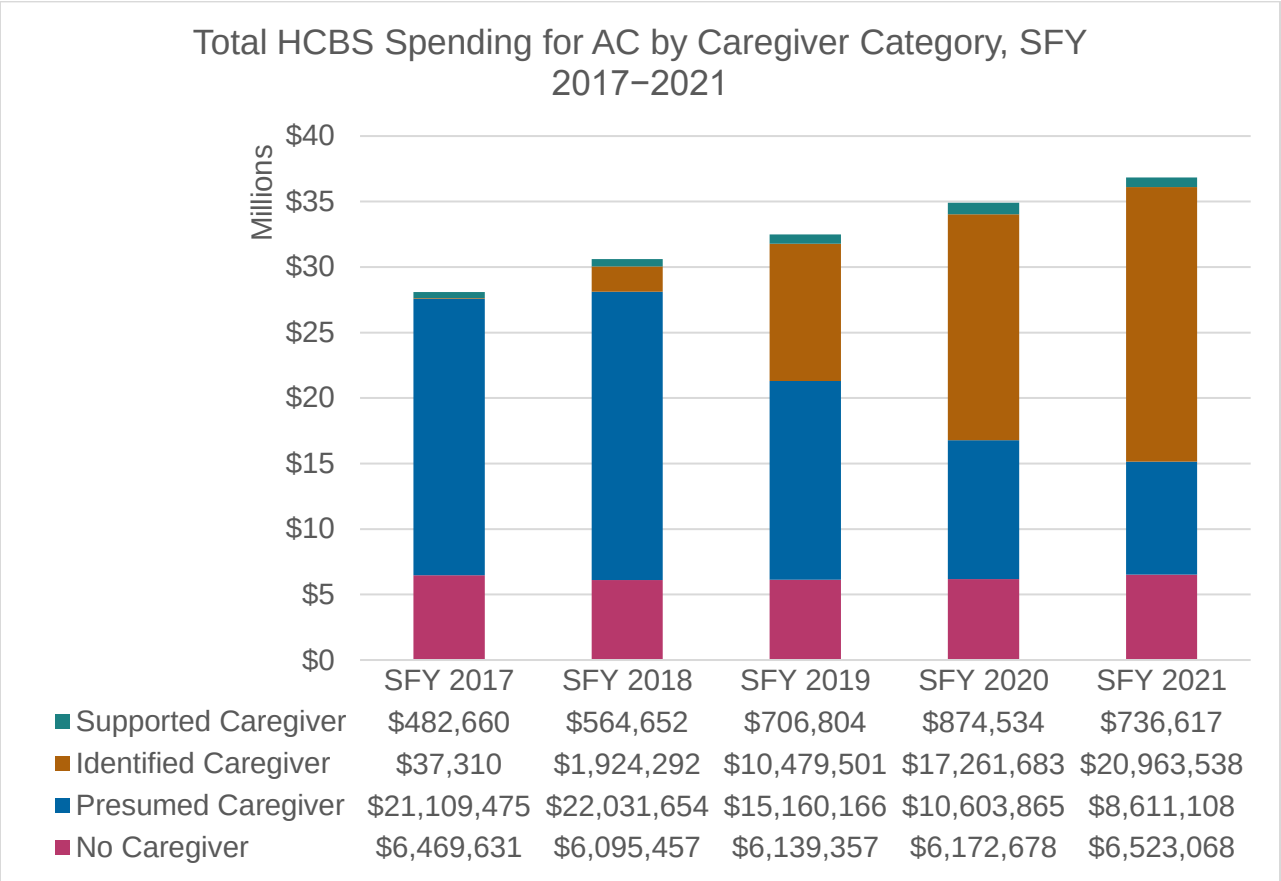
Figure 19. OAA Participant Living Arrangements by Presence of Caregiver, SFYs 2017−2021



Total Program Utilization

The data presented in the Total Program Utilization section represent all HCBS service data provided for each of the three programs in scope. HCBS spending within AC grew more than 30 percent in SFYs 2017−2021 (see Figure 20). Similar to observations regarding the pattern of participants in the caregiver categories, with more participants having identified caregivers in later years of the data, a significant increase in spending is observable in this group.

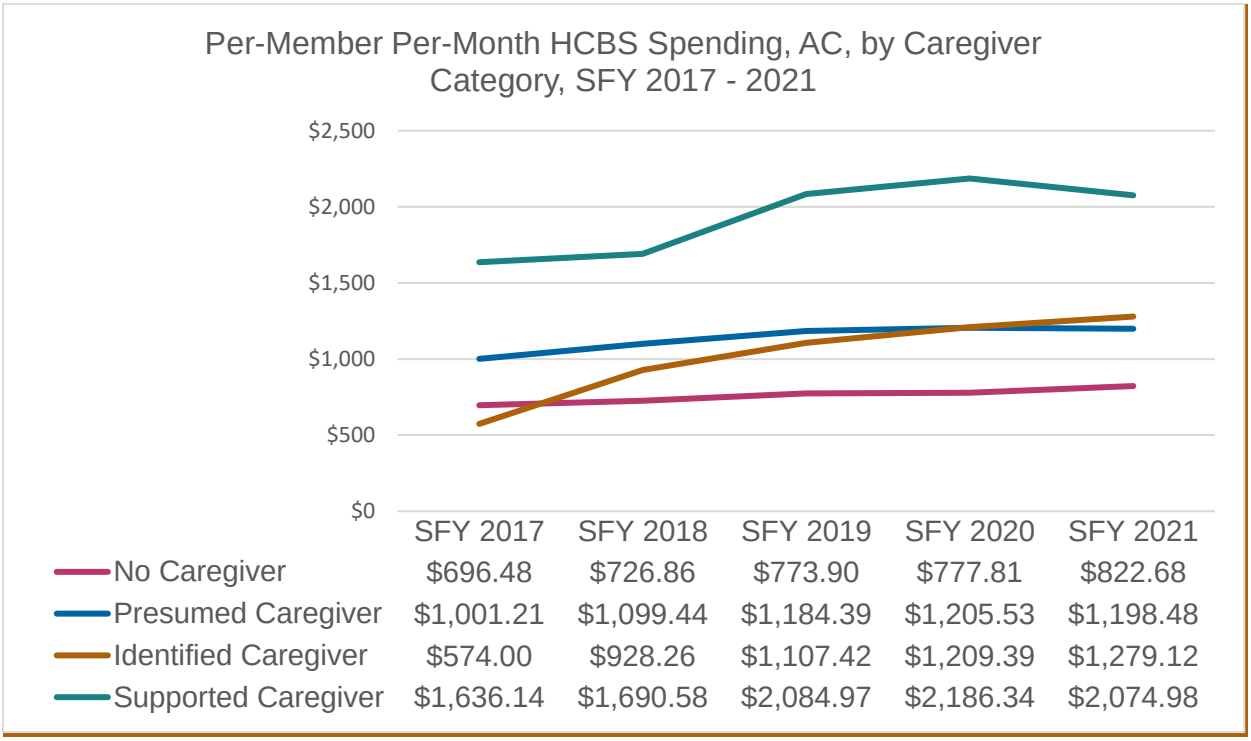
Figure 20. Total HCBS Spending for AC by Caregiver Category, SFYs 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Supported Caregiver	$482,660	$564,652	$706,804	$874,534	$736,617
Identified Caregiver	$37,310	$1,924,292	$10,479,501	$17,261,683	$20,963,538
Presumed Caregiver	$21,109,475	$22,031,654	$15,160,166	$10,603,865	$8,611,108
No Caregiver	$6,469,631	$6,095,457	$6,139,357	$6,172,678	$6,523,068

With the total spending growth driven by the number of participants in each group, in addition to evolving service delivery practices, on a per-member per-month (PMPM) basis, participants who had supported or identified caregivers saw their average monthly spending increase to a larger degree than participants with presumed or no caregivers. Figure 21 shows that monthly spending in AC for the supported caregiver and identified caregiver categories grew 27 percent and 123 percent, respectively.

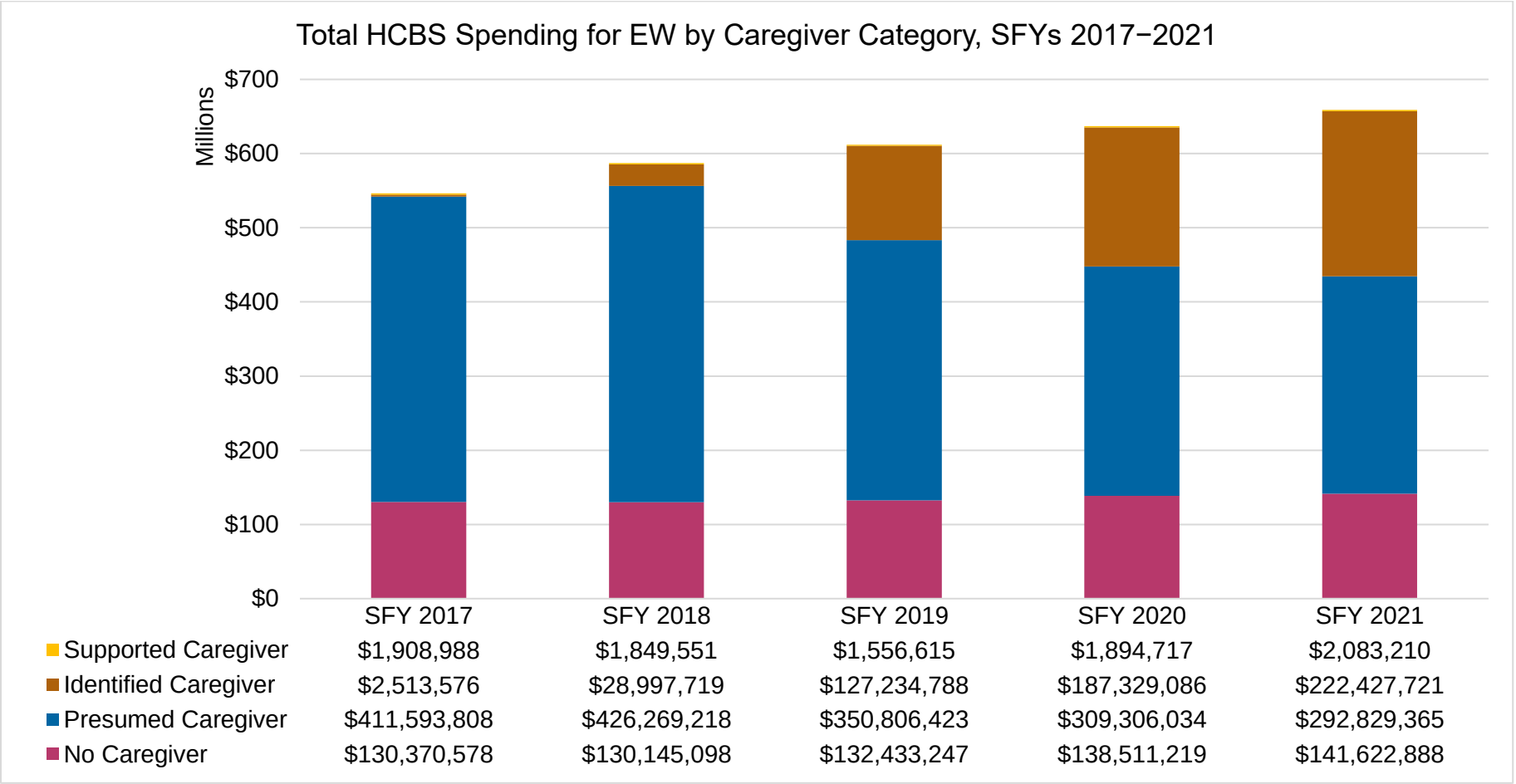
Figure 21. Per-Member Per-Month HCBS Spending for AC by Caregiver Category, SFY 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No Caregiver	$696.48	$726.86	$773.90	$777.81	$822.68
Presumed Caregiver	$1,001.21	$1,099.44	$1,184.39	$1,205.53	$1,198.48
Identified Caregiver	$574.00	$928.26	$1,107.42	$1,209.39	$1,279.12
Supported Caregiver	$1,636.14	$1,690.58	$2,084.97	$2,186.34	$2,074.98

The HCBS spending trends for EW are similar to AC, with a significant spending increase in the identified caregiver category (see Figures 22 and 23). These observations are not causal in nature; spending growth could be attributed to multiple factors not captured by caregiver category assignment. The presumed caregiver category's spending shows a decline, with growth in the number of program participants with identified caregivers.

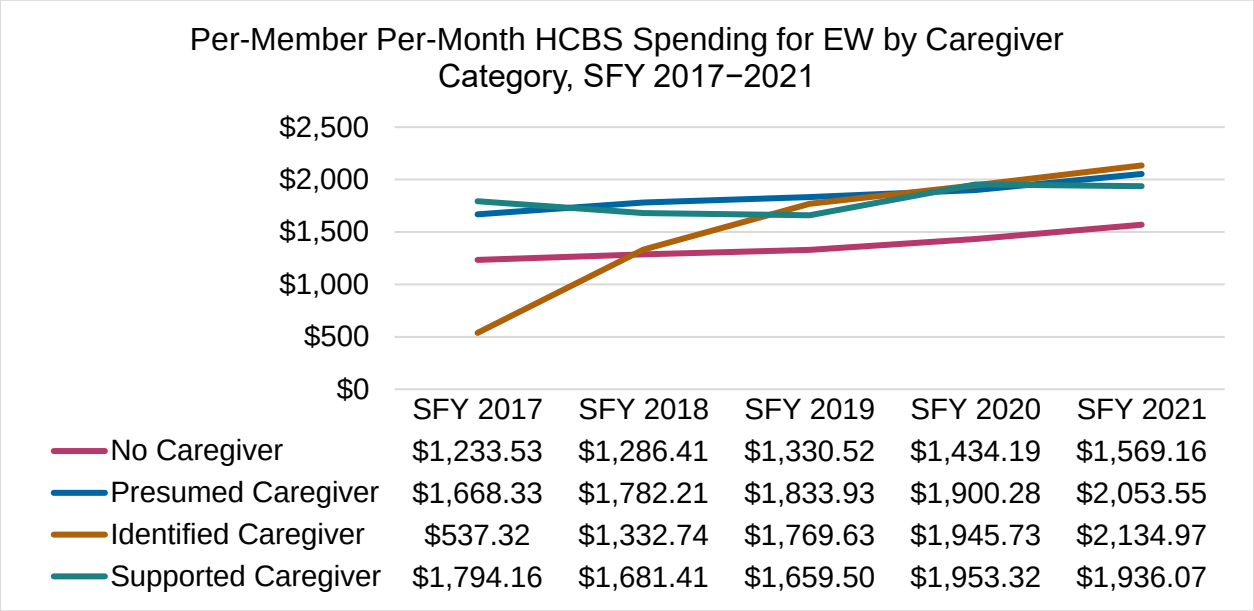
Figure 22. Total HCBS Spending for EW by Caregiver Category, SFYs 2017− 2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Supported Caregiver	$1,908,988	$1,849,551	$1,556,615	$1,894,717	$2,083,210
Identified Caregiver	$2,513,576	$28,997,719	$127,234,788	$187,329,086	$222,427,721
Presumed Caregiver	$411,593,808	$426,269,218	$350,806,423	$309,306,034	$292,829,365
No Caregiver	$130,370,578	$130,145,098	$132,433,247	$138,511,219	$141,622,888

When viewed as average monthly spending, the identified caregiver category experienced tremendous growth (approximately 400%) in 2017−2021. Figure 23 also indicates that participants with no caregiver had the lowest monthly spending on average in each of the years.

Figure 23. Per-Member Per-Month HCBS Spending for EW by Caregiver Category, SFY 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No Caregiver	$1,233.53	$1,286.41	$1,330.52	$1,434.19	$1,569.16
Presumed Caregiver	$1,668.33	$1,782.21	$1,833.93	$1,900.28	$2,053.55
Identified Caregiver	$537.32	$1,332.74	$1,769.63	$1,945.73	$2,134.97
Supported Caregiver	$1,794.16	$1,681.41	$1,659.50	$1,953.32	$1,936.07

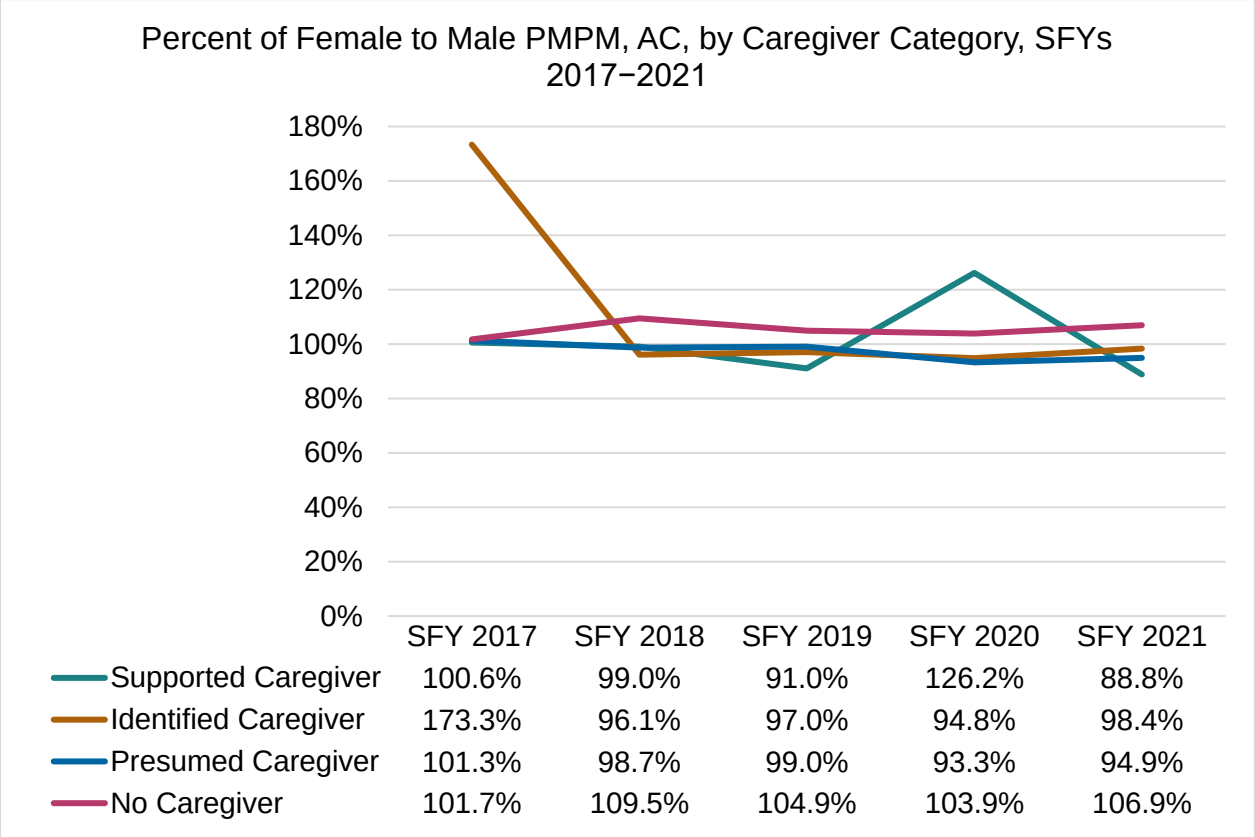
Program Utilization by Demographic Categories

Observable differences in service utilization and spending are apparent when the AC and EW participants are viewed through the lens of demographic variation. Because the OAA program demographic data are less comprehensive and consistent, our demographic analyses on spending do not include OAA services. In both AC and EW, females have higher spending than males, particularly with the presence of a supported or identified caregiver (Figures 24 and 25). The individual programs have different patterns across age groups. Older EW participants generally display higher spending than younger groups, whereas the youngest cohort of AC participants has the highest spending average. The highest race/ethnicity group spending in both programs is White because of population size. However, average monthly spending is highest for people who are Native Americans or Alaskan Natives in EW and people who are Asian or Pacific Islander for EW. Participants in metro regions had both the most spending and highest average spending compared with urban and rural regions.

Sex

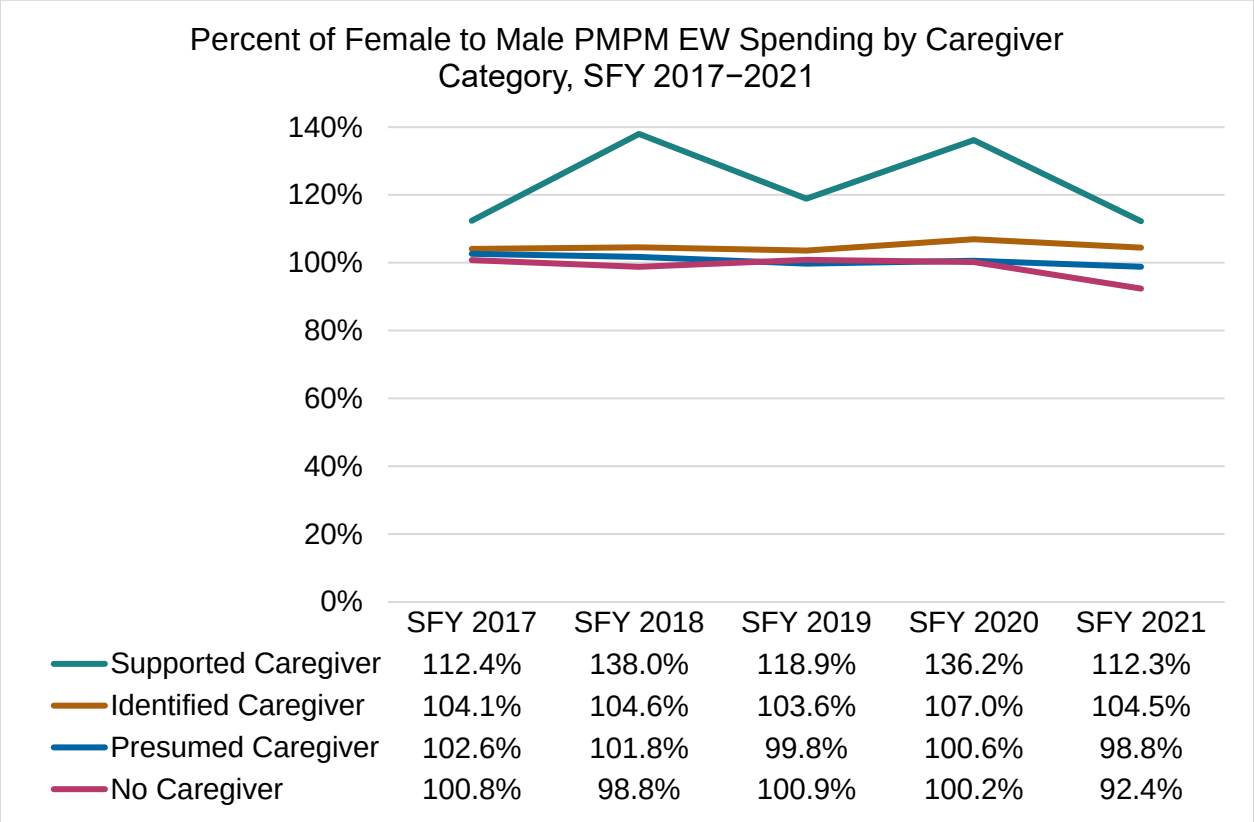
Figures 24 and 25 show the difference in average monthly spending between females and males by caregiver category in AC and EW. If the two sexes had equal spending, the value would equal 100 percent. Generally, females have higher spending than males, but they are fairly close. There is also a relative trend of female spending decreasing as compared with males over the study period.

Figure 24. Percent of Female to Male PMPM Spending in AC by Caregiver Category, SFY 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Supported Caregiver	100.6%	99.0%	91.0%	126.2%	88.8%
Identified Caregiver	173.3%	96.1%	97.0%	94.8%	98.4%
Presumed Caregiver	101.3%	98.7%	99.0%	93.3%	94.9%
No Caregiver	101.7%	109.5%	104.9%	103.9%	106.9%

Figure 25. Percent of Female to Male PMPM EW Spending by Caregiver Category, SFYs 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Supported Caregiver	112.4%	138.0%	118.9%	136.2%	112.3%
Identified Caregiver	104.1%	104.6%	103.6%	107.0%	104.5%
Presumed Caregiver	102.6%	101.8%	99.8%	100.6%	98.8%
No Caregiver	100.8%	98.8%	100.9%	100.2%	92.4%

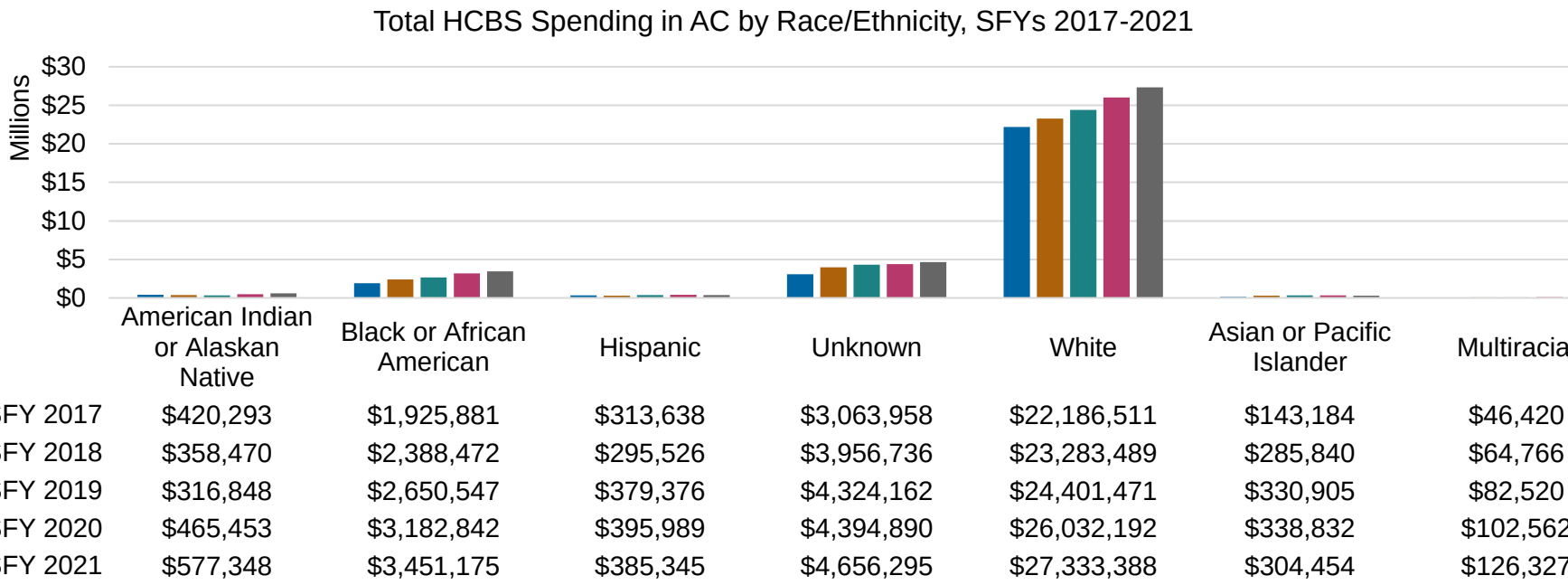
Age

Among AC program participants, the 65−74-year-old age group has the highest average monthly spending. With and across age groups there are also significant difference when age interacts with caregiver category with supported caregivers, albeit amount of people, among the age 95 and older population with spending at 337 percent of the annual PMPM in 2017, while those ages 75 to 84 in that same year had less than half of the annual PMPM value. The data book accompanying this report provides stratified analysis of program spending.

Race/Ethnicity

In both programs, the largest portion of spending is attributable to the White population given its dominant size in both the programs and Minnesota. As Figure 26 shows, the unknown race/ethnicity group has the next highest spending, followed by the Black or African American population. White program participants accounted for more than three times the total spending of other race/ethnicity groups in AC.

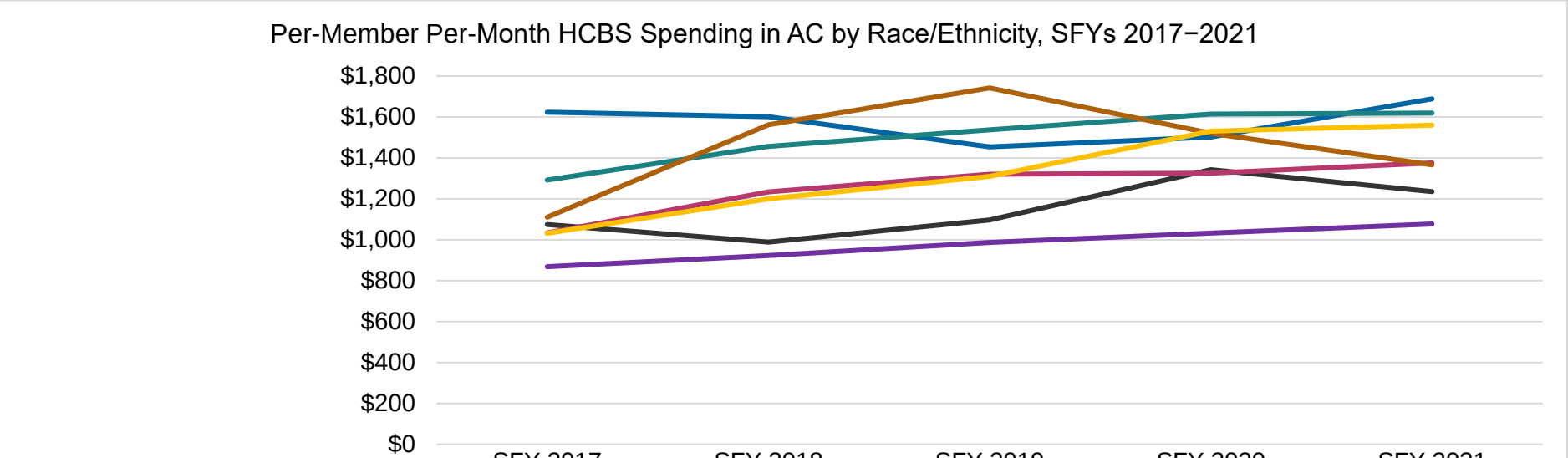
Figure 26. Total HCBS Spending in AC by Race/Ethnicity, SFYs 2017–2021



	American Indian or Alaskan Native	Black or African American	Hispanic	Unknown	White	Asian or Pacific Islander	Multiracial
SFY 2017	$420,293	$1,925,881	$313,638	$3,063,958	$22,186,511	$143,184	$46,420
SFY 2018	$358,470	$2,388,472	$295,526	$3,956,736	$23,283,489	$285,840	$64,766
SFY 2019	$316,848	$2,650,547	$379,376	$4,324,162	$24,401,471	$330,905	$82,520
SFY 2020	$465,453	$3,182,842	$395,989	$4,394,890	$26,032,192	$338,832	$102,562
SFY 2021	$577,348	$3,451,175	$385,345	$4,656,295	$27,333,388	$304,454	$126,327

Observations on PMPM spending, paint a different picture compared with total spending in AC, with the White program participants having lower monthly spending than other program participants. While Figure 27 shows some changes in the ranked order of PMPM year over year, the Native American or Alaskan Native population begins and ends the study period with the highest PMPM value.

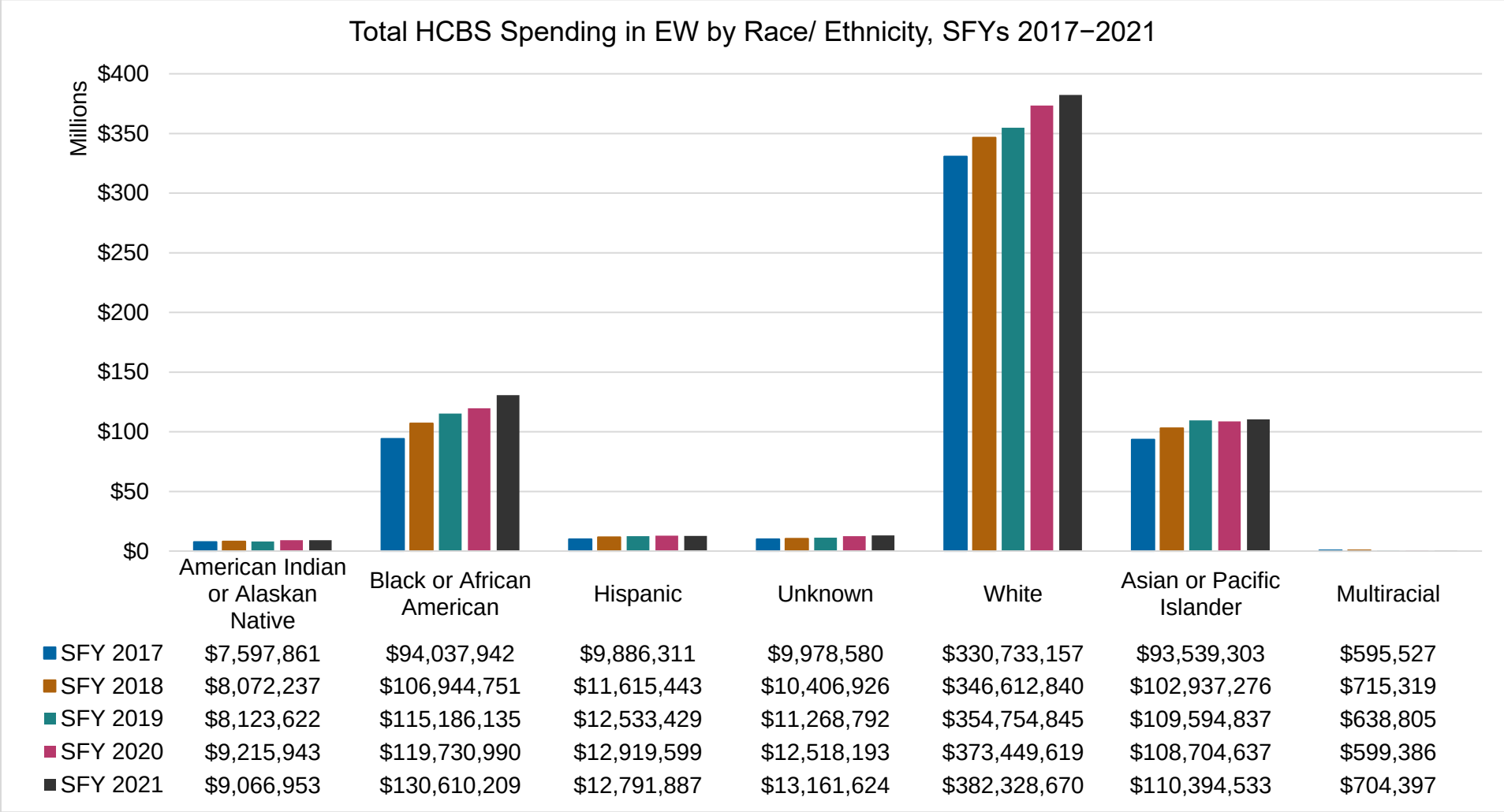
Figure 27. Per-Member Per-Month HCBS Spending in AC by Race/Ethnicity, SFYs 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
American Indian or Alaskan Native	$1,622.75	$1,600.31	$1,453.43	$1,501.46	$1,688.15
Black or African American	$1,291.67	$1,455.50	$1,536.55	$1,614.02	$1,618.75
Hispanic	$1,074.10	$988.38	$1,096.46	$1,342.33	$1,235.08
Unknown	$1,033.38	$1,233.40	$1,319.95	$1,324.56	$1,375.16
White	$868.22	$922.41	$987.23	$1,032.20	$1,076.88
Asian or Pacific Islander	$1,109.95	$1,561.97	$1,741.60	$1,519.43	$1,365.26
Multiracial	$1,031.55	$1,199.38	$1,309.83	$1,530.78	$1,559.59

Within the EW program, White participants once again are the largest source of spending, but they are nearly one-and-a-half times larger than other groups, compared to three times larger than other populations in AC. Black and African American participants have the second-highest amount of spending, followed by Asian or Pacific Islander (see Figures 26 and 27).

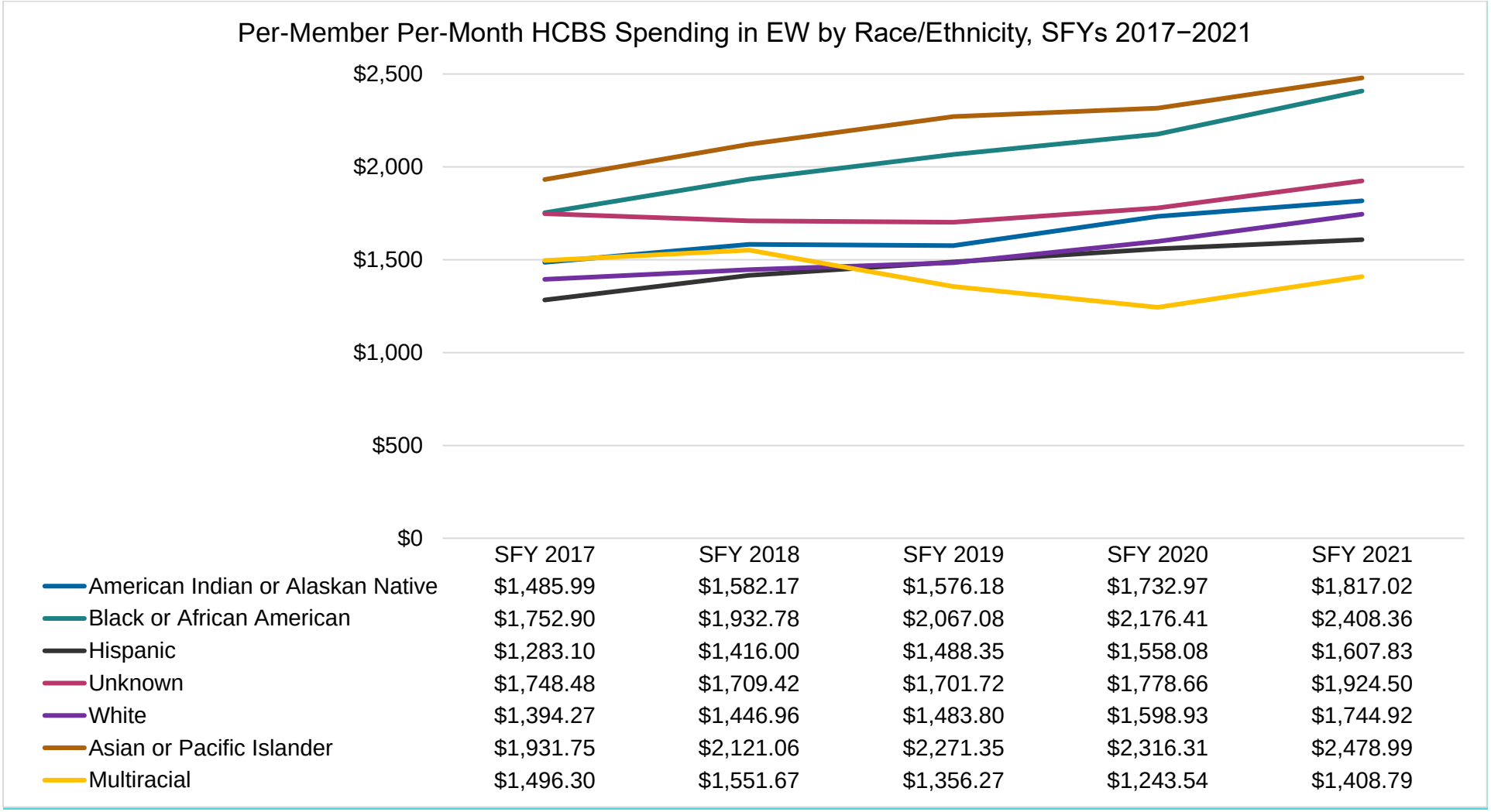
Figure 28. Total HCBS Spending in EW by Race/Ethnicity, SFYs 2017–2021



	American Indian or Alaskan Native	Black or African American	Hispanic	Unknown	White	Asian or Pacific Islander	Multiracial
SFY 2017	$7,597,861	$94,037,942	$9,886,311	$9,978,580	$330,733,157	$93,539,303	$595,527
SFY 2018	$8,072,237	$106,944,751	$11,615,443	$10,406,926	$346,612,840	$102,937,276	$715,319
SFY 2019	$8,123,622	$115,186,135	$12,533,429	$11,268,792	$354,754,845	$109,594,837	$638,805
SFY 2020	$9,215,943	$119,730,990	$12,919,599	$12,518,193	$373,449,619	$108,704,637	$599,386
SFY 2021	$9,066,953	$130,610,209	$12,791,887	$13,161,624	$382,328,670	$110,394,533	$704,397

The Asian or Pacific Islander category consistently has the highest PMPM value in EW followed not far behind by the Black or African American group. Figure 29 also shows spending for those groups trends at a higher rate than the other race/ethnicity categories.

Figure 29. PMPM HCBS Spending in EW by Race/Ethnicity, SFYs 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
American Indian or Alaskan Native	$1,485.99	$1,582.17	$1,576.18	$1,732.97	$1,817.02
Black or African American	$1,752.90	$1,932.78	$2,067.08	$2,176.41	$2,408.36
Hispanic	$1,283.10	$1,416.00	$1,488.35	$1,558.08	$1,607.83
Unknown	$1,748.48	$1,709.42	$1,701.72	$1,778.66	$1,924.50
White	$1,394.27	$1,446.96	$1,483.80	$1,598.93	$1,744.92
Asian or Pacific Islander	$1,931.75	$2,121.06	$2,271.35	$2,316.31	$2,478.99
Multiracial	$1,496.30	$1,551.67	$1,356.27	$1,243.54	$1,408.79

Region

Regional variation by both total spending and PMPM follow a consistent pattern of metro having the highest total and average spending in AC (see Figures 30 and 31). This trend perhaps could be attributed to both population size and relative availability of support services providers in AC. Though urban areas represent the lowest category of total spending, they do have a higher PMPM than rural regions through much of the study period.

Figure 30. Total HCBS Spending in AC by Region, SFYs 2017−2021

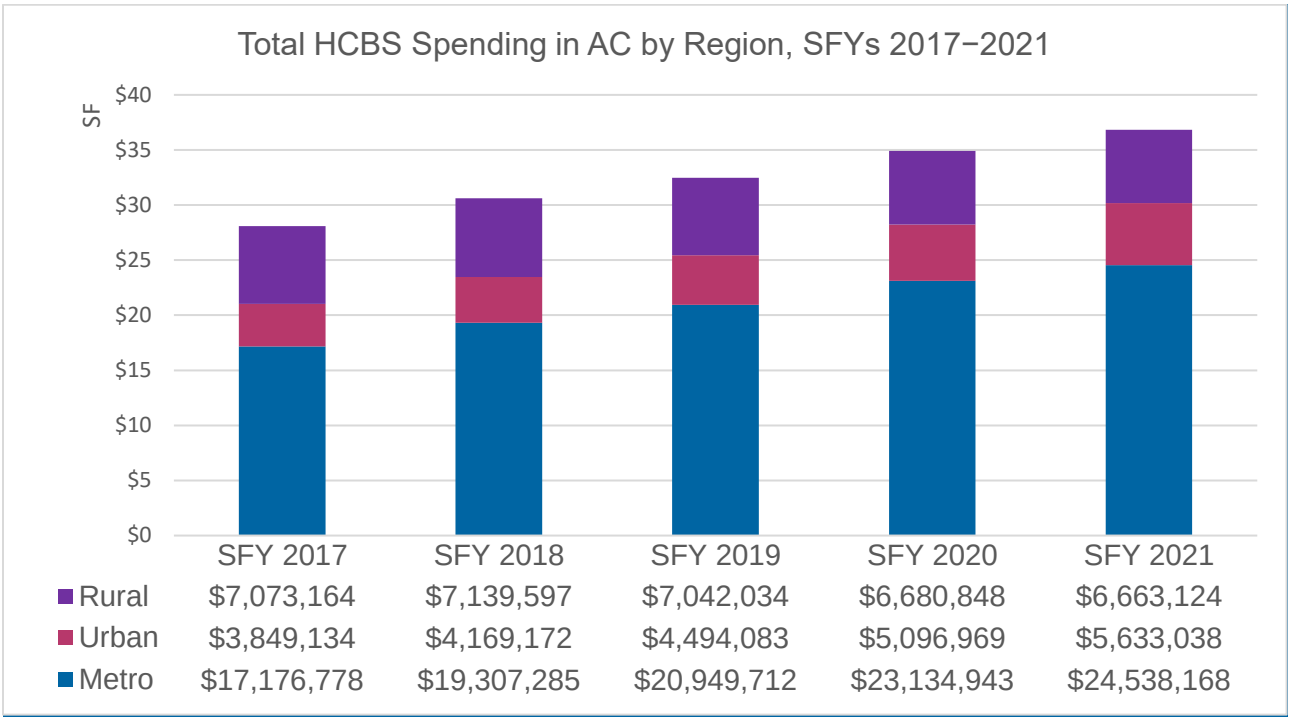
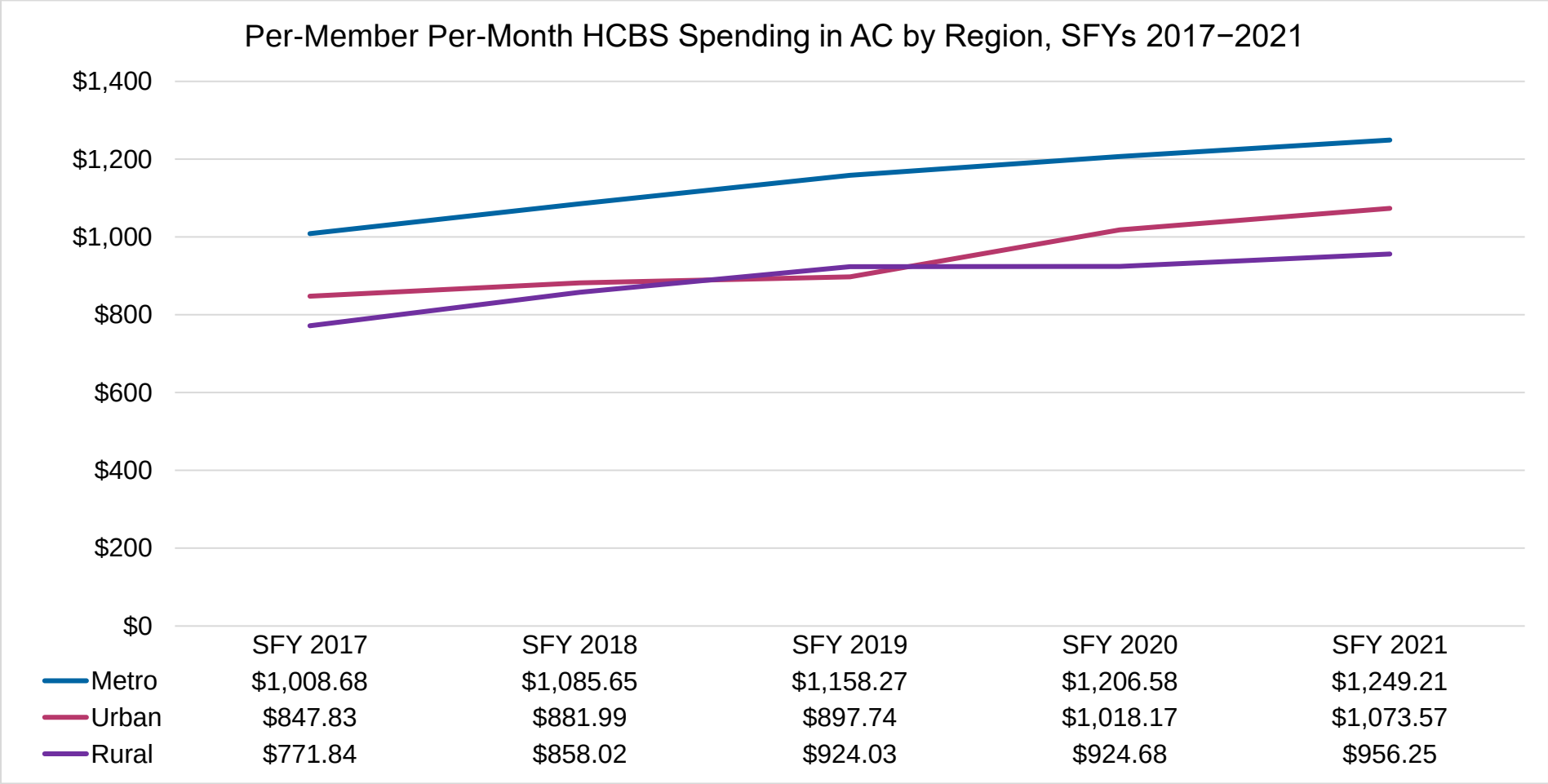


Figure 31. PMPM HCBS Spending in AC by Region, SFY 2017−2021



	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Metro	$1,008.68	$1,085.65	$1,158.27	$1,206.58	$1,249.21
Urban	$847.83	$881.99	$897.74	$1,018.17	$1,073.57
Rural	$771.84	$858.02	$924.03	$924.68	$956.25

As with AC, the metro category has the highest total spending and PMPM in EW and grew at a higher percent than urban and rural over the course of the study. Rural PMPM was the lowest of the categories but has grown at a faster rate than the urban category (see Figures 32 and 33).

Figure 32. Total HCBS Spending in EW by Region, SFY 2017−2021

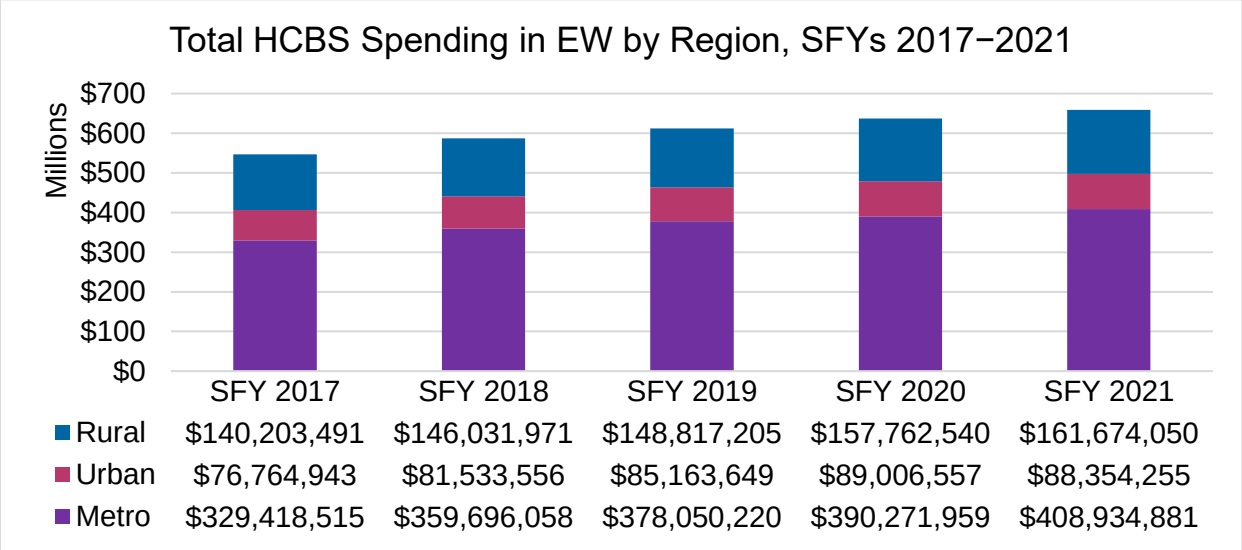
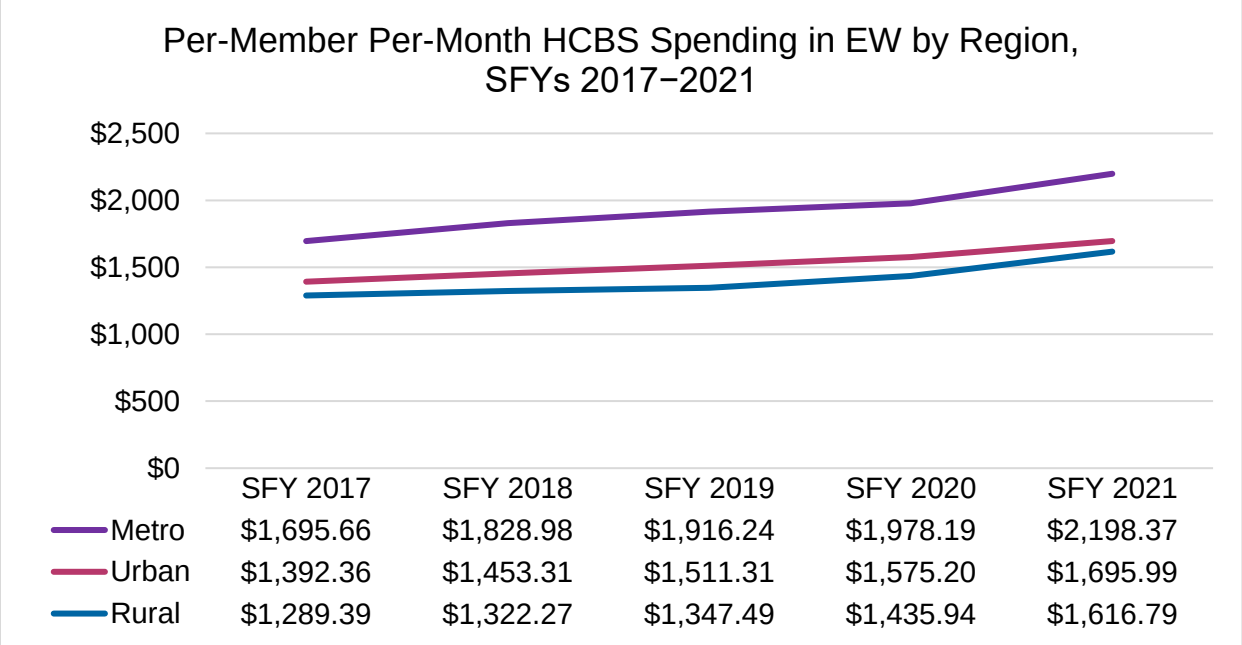


Figure 33. PMPM HCBS Spending in EW by Region, SFYs 2017−2021



Primary Caregiver Support Services Utilization

The primary caregiver support services covered in the scope of this analysis include caregiver training and education, caregiver coaching and counseling, and respite. Compared with total HCBS spending in the three programs, these primary supports have been modest in their spending and utilization, though both are clearly growing.

Within the AC program, less than $2,000 total were spent on caregiver training and education but spending on respite care more than doubled in from $112,631 in 2017 to $242,549 in 2021 (see Table 14).

Table 14. Total Primary Caregiver Support Spending in AC by Service, SFYs 2017–2021

AC	Primary Caregiver Support Spending in AC for SFY 2017	Primary Caregiver Support Spending in AC for SFY 2018	Primary Caregiver Support Spending in AC for SFY 2019	Primary Caregiver Support Spending in AC for SFY 2020	Primary Caregiver Support Spending in AC for SFY 2021
Caregiver Training and Education	$0	$362	$290	$869	$272
Respite Care Services	$112,631	$142,302	$170,862	$247,008	$242,277
Primary Caregiver Supports Total	**$112,631**	**$142,664**	**$171,152**	**$247,877**	**$242,549**

In addition to total spending growth, the PMPM for primary caregiver support services in AC grew nearly 80 percent during the study period (see Table 15), which speaks to Minnesota's commitment to supporting caregivers and indicates further potential.

Table 15. Mean PMPM Primary Caregiver Support Spending in AC by Service, SFYs 2017–2021

AC	Mean PMPM Primary Caregiver Support Spending in AC for SFY 2017	Mean PMPM Primary Caregiver Support Spending in AC for SFY 2018	Mean PMPM Primary Caregiver Support Spending in AC for SFY 2019	Mean PMPM Primary Caregiver Support Spending in AC for SFY 2020	Mean PMPM Primary Caregiver Support Spending in AC for SFY 2021
Caregiver Training and Education	$0.00	$1.08	$0.85	$2.17	$0.77
Respite Care Services	$381.80	$426.05	$504.02	$617.52	$682.47
Primary Caregiver Supports PMPM	**$190.90**	**$213.57**	**$252.44**	**$309.85**	**$341.62**

Total primary caregiver support spending is greater in EW than in AC—unsurprising given the scale of the two programs. Of particular note is the large jump in caregiver training and education, which increased seven-fold in 2020−2021. Table 16 also shows that respite care spending, while having some variation, is flatter, with a small decline over the study period.

Table 16. Total Primary Caregiver Support Spending in EW by Service, SFYs 2017–2021

EW	Total Primary Caregiver Support Spending in EW for SFY 2017	Total Primary Caregiver Support Spending in EW for SFY 2018	Total Primary Caregiver Support Spending in EW for SFY 2019	Total Primary Caregiver Support Spending in EW for SFY 2020	Total Primary Caregiver Support Spending in EW for SFY 2021
Caregiver Training and Education	$761	$706	$0	$887	$7,354
Respite Care Services	$374,870	$405,592	$375,090	$329,679	$337,500
Primary Caregiver Supports Total	$375,630	$406,298	$375,090	$330,566	$344,854

Driven by respite spending, the PMPM displays a pyramid pattern of rising use in 2017−2021 and declines in the last two years (see Table 17). It might be worth investigating the underlying differences between use of respite care services in the AC and EW programs.

Table 17. Mean PMPM Primary Caregiver Support Spending in EW by Service, SFYs 2017–2021

EW	Mean PMPM Primary Caregiver Support Spending in EW for SFY 2017	Mean PMPM Primary Caregiver Support Spending in EW for SFY 2018	Mean PMPM Primary Caregiver Support Spending in EW for SFY 2019	Mean PMPM Primary Caregiver Support Spending in EW for SFY 2020	Mean PMPM Primary Caregiver Support Spending in EW for SFY 2021
Caregiver Training and Education	$0.71	$0.64	$0.00	$0.91	$6.83
Respite Services	$352.32	$368.72	$399.88	$339.88	$313.66
Primary Caregiver Supports PMPM	$176.52	$184.68	$199.94	$170.39	$160.25

OAA Services

The Administration on Community Living's Title III Programs 2020 Program Results report indicates that 186,000 people who give care to older adults received more than 5 million hours of respite services and engaged in more than 530,000 counseling, support group, and/or caregiver training sessions.[17] Table 18 displays Minnesota's primary caregiver services delivered through OAA supports.

The data in Table 18 are displayed as Scenario 1 and Scenario 2. Scenario 1 focuses on people who have blank values for marital status and describe their living arrangement as not having a caregiver, which might lead to an overstatement of the number of people in the no caregiver category. Scenario 2 removes those people from the analysis, which reduces overall service provision reported, but also removes the bias that including them all in the no caregiver category would create. Further OAA data limitations are described in the Data Used for this Project section of this report.

As might be expected, supported caregivers most frequently use support services but do turn to other services as well. Only supported caregivers use respite services. In comparison, the annual utilization per 1,000 measure is similar to the EW program, which averages 32,975 annual uses per 1,000 (data not shown).

Table 18. OAA Primary Caregiver Services Use Profiles by Caregiver Category

		SCENARIO 1			SCENARIO 2		
Population	**Service Type**	**Scenario 1 Utilizer Months (UMs)**	**Scenario 1 Units**	**Scenario 1 Annual Utilization /1000**	**Scenario 2 Utilizer Months (UMs)**	**Scenario 2 Units**	**Scenario 2 Annual Utilization /1000**
Supported Caregiver	Caregiver Support Services	73,517	245,582	40,086	57,457	204,579	42,727
Supported Caregiver	Homemaker	73,517	4,927	804	57,457	4,406	920
Supported Caregiver	Respite	73,517	226,575	36,983	57,457	164,245	34,303
Supported Caregiver	N/A	73,517	169,183	27,615	57,457	167,262	34,933
Identified Caregiver	Caregiver Support Services	28,477	455	192	28,477	455	192
Identified Caregiver	Homemaker	28,477	9,550	4,024	28,477	9,550	4,024
Identified Caregiver	Respite	28,477	-	-	28,477	-	-
Identified Caregiver	N/A	28,477	297,669	125,435	28,477	297,669	125,435
Presumed Caregiver	Caregiver Support Services	542,927	2,476	55	542,927	2,476	55

Presumed Caregiver	Homemaker	542,927	26,737	591	542,927	26,737	591
Presumed Caregiver	Respite	542,927	-	-	542,927	-	-
Presumed Caregiver	N/A	542,927	4,803,239	106,163	542,927	4,803,239	106,163
No Caregiver	Caregiver Support Services	779,648	7,427	114	730,970	6,956	114
No Caregiver	Homemaker	779,648	131,628	2,026	730,970	124,219	2,039
No Caregiver	Respite	779,648	-	-	730,970	-	-
No Caregiver	N/A	779,648	10,839,297	166,834	730,970	10,067,324	165,271
Total		**1,424,569**	**16,764,745**	**141,220**	**1,359,831**	**15,879,118**	**140,127**

Secondary Caregiver Support Services

Our analysis also took a preliminary look at secondary caregiver support services, inclusive of adult companion services, adult day services, homemaker services, individual community living support services, and personal care assistance. Secondary caregiver support services cost an average of approximately $14 million annually for AC and $251 million annually for EW, representing a little more than 40 percent of total HCBS spending in each program. Similar demographic differences exist within secondary support services as identified in total service spending, which warrants demographic analyses to be figured into future health equity efforts and the program improvement initiatives and evaluations outlined later in this report.

HCBS EQUITY: UNDERSTANDING HEALTH EQUITY IN THE CONTEXT OF MINNESOTA

The Minnesota State Demographic Center estimates that the state's age 65+ population will total 1.26 million by 2075, a 35 percent increase from 2020. In addition, while older adults in Minnesota are more likely to be White, the number of Minnesotans of color will increase by at least 1 million by 2050, driving up the number of people of color aging into older adulthood. This demographic shift will have implications for the coordination, delivery, and financing of formal, paid HCBS and unpaid HCBS family caregivers provide. In addition, HCBS need, defined by age at onset, service and support type(s), intensity, and duration, is unevenly distributed. People of color and older adults with limited resources (e.g., income) are more likely to require paid, formal LTSS for longer periods relative to their White or more affluent counterparts. As Minnesota's population continues to diversify across multiple dimensions of identity (e.g., race, ethnicity, gender/gender expression, sexual orientation), data-driven approaches grounded in principles of equity will be required to expand access to high-quality, person-centered HCBS and caregiver supports and reduce health disparities.

Health Equity Definitions

Racial and ethnic inequities in healthcare outcomes and opportunities to achieve optimal health are well documented in the literature and in myriad communities. DHS defines health disparities, health equity, and health inequities as follows:

- **Health disparities**: Differences in health that are intricately linked with social, economic, or environmental disadvantage. Health disparities affect groups that systematically experience greater obstacles, including communities of color, Native Americans, and people with disabilities.[16]
- **Health equity**: Health equity is realized when everyone has the opportunity to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequalities.[17]
- **Health inequities**: Avoidable differences in health between groups of people, which are caused by systematic differences in social conditions and processes that effectively determine health such as differences in access to care, the ability to afford treatment, or exposure to risks or trauma. Health inequities are avoidable, unjust, and therefore actionable.[18]

Framing Disparities in HCBS Access, Usage, and Outcomes

Nationally, individuals who identify as BIPOC (Black, Indigenous, and People of Color) have unequal access to HCBS because of multiple interpersonal, structural, and systemic factors. Manifestations of discrimination include limited availability of person-centered resources and fewer community-based options in underserved, predominantly BIPOC residential areas or low-income communities.

Despite states' efforts to address institutional bias in LTSS, disparities in access to community-based programs and public spending remain. The US Supreme Court's landmark Olmstead decision (1999) upheld the federal Americans with Disabilities Act (1990) community integration mandate, catalyzing a shift of public resources away from institutional care toward community options that promote personal agency, independence, and dignity.[19] Under Medicaid, the nation's primary payer for formal LTSS, HCBS expenditures surpassed the 50 percent rebalancing benchmark in fiscal year (FY) 2013 while outlays for HCBS that older adults and people with disabilities use exceeded this

longstanding threshold in only seven states (Massachusetts, Minnesota, New York, New Mexico, Oregon, Texas, and Washington) and the District of Columbia.[20]

Though every state offers Medicaid HCBS (home health is the only mandatory HCBS benefit under federal statute; all other HCBS are offered as a state option), the federal government does not incentivize states to focus on racial and ethnic equity within and across programs. No standardized measures of quality care experiences have been set for state Medicaid HCBS programs. Under the federal Older Americans Act (1965), services and supports comprise HCBS (e.g., home-delivered meals, in-home services, non-emergency transportation, and caregivers supports).[21]

The United States will need millions of trained direct care workers (DCWs), also referred to as direct service workers or direct support professionals, to support older adults at home and in the community in the coming decades.[22] DCWs' racial or ethnic background and immigration status, as well as other demographic factors (e.g., nationality), have implications for the delivery of culturally and linguistically responsive LTSS. Diverse racial and ethnic groups and immigrants, who are underrepresented across all sectors of the US workforce, are overrepresented in the direct care workforce. In 2017, 62 percent of home healthcare workers identified as Black/African American, Hispanic/Latino (any race), Asian/Pacific Islander, or other.

Nearly one-third (31%) of home health workers were not US citizens by birth.[23] In addition, Medicaid reimbursement rates remain low, especially in high-poverty states with greater shares of residents of color. Medicaid reimbursement for family caregivers and legally responsible persons has implications for racial equity in HCBS given the disproportionate share of people of color who serve as unpaid, informal caregivers.

Data are critical to the feasibility and effectiveness of measuring equity in HCBS. Efforts to use public and private sector data to measure HCBS system performance (e.g., the AARP LTSS Scorecard) or social and health outcomes among HCBS recipients and their caregivers historically have not been grounded in principles of equity or explored potential disparities that exist by race and ethnicity.

Overview of DHS Initiatives to Advance Health Equity

2020–2022 Agencywide Strategic Plan

With a vision of engendering "better health, fuller life, and lower cost for Minnesotans working to achieve their highest potential," the 2020–2022 DHS Strategic Plan notes several internal and public-facing strategies to advance equitable access, services, and experiences. Goal 2 outlines an internal strategy whereby DHS will apply equity review tools "to evaluate every DHS service and to improve the intercultural skills of DHS staff to design equitable services and equitable access."[24] The strategic plan outlines a vision for a culture of equity through a four-pronged strategy to "institutionalize equity practices across the agency" and "provide employees with the tools and skills to establish equity in the workplace."[25]

Cultural and Ethnic Communities Leadership Council

The Cultural and Ethnic Communities Leadership Council was established during the 2013 legislative session. The DHS Commission appoints 15–25 members representing racial and ethnic minority communities, tribal service providers, advocacy and faith-based organizations, DHS program participants, and human services legislative committee leaders to the council. Council members review DHS policies for "racial, ethnic, cultural, linguistic, and tribal disparities" and draft an annual report on the extent to which services are delivered equitably. In addition, the council drafted the DHS Policy on Equity, which the department approved in 2017.[26]

Dementia Grants

The MBA has been investing up to $750,000 in the form of annual dementia grants for the past several years. The awards process is competitive, with the goal of funding projects that increase awareness of dementia and the rate of screening as well as initiatives that promote early identification and focus on connecting friends and caregivers to resources and supports. The grant application requires applicants to describe the target population and offers up to 50 additional points for applicants who further identify an intentional focus area that targets a specific culture, ethnic population, or rural community. Grantees over the past several years have implemented projects and programs that serve the needs of elders and their caregivers in the Latino, Upper Sioux, Laotian, South Asian, African-American, East African, Native American, LGBTQ+, and rural communities.

Live Well at Home Grants

Since its inception in 2001, the Live Well at Home grant opportunity has aimed to expand access to and integrate an array of affordable community-based and other services that divert or delay institutional placement among Minnesotans ages 65 and older who would prefer to age in place. Specifically, the purpose of this grant is to:

- Improve communities' capacity to develop, strengthen, integrate, and maintain culturally competent formal and informal HCBS
- Maintain HCBS for older adults at risk for institutional placement and/or spending down to meet Medicaid financial eligibility
- Enhance services for the caregiver support network
- Improve chronic disease management
- Promote independence through market-based solutions
- Stimulate innovation
- Align across a variety of federal, state, local, and private funding sources

For example, grantees—nonprofit agencies, for-profit businesses, units of government, and Tribal Nations—receive one-time start-up funds to test new approaches in housing, core HCBS development, and respite care or fund capital and renovation projects to increase HCBS system capacity in rural areas or for BIPOC populations. In SFY 2023, the Minnesota Legislature appropriated approximately $8 million to DHS for this grant opportunity.

Grants, Equity, Access, and Research Division Provider Capacity Grant for Rural and Undeserved Communities

The Grants, Equity, Access, and Research (GEAR) Division's provider capacity grant opportunity targets new and existing HCBS provider entities that serve older adults and people with disabilities to support an array of goals (e.g., expanded access to culturally concordant service delivery) in rural and regional centers outside the seven-county metro area.[27] The grant awards are funded through the federal American Rescue Plan Act (ARPA) of 2021.[28]

Age-Friendly Minnesota Community Grants

Through a collaboration with the Age-Friendly Minnesota Council, DHS launched a new grant opportunity in 2022 to support age-friendly efforts led by community-based organizations. The 12-month grant cycle is to begin in 2023.[29] The Age Friendly Minnesota Council is committed to making diversity, equity, inclusion, and accessibility (DEIA) the foundation of this grants program.

HCBS Evaluation of Assessments for Racial and Ethnic Disparities (HEARD).

Through a partnership with the University of Minnesota and Purdue University, DHS is conducting quantitative research on racial and ethnic disparities in HCBS assessment, enrollment, and service utilization patterns, as well as participant self-reported satisfaction.[30] Now in Phase II, the evaluation will focus on additional community engagement and qualitative research to "amplify voices of BIPOC HCBS participants to share practices that are successfully addressing people's needs and preferences across cultures, race, and ethnicity."[31]

Caregiver Supports Training Touchpoints for Navigators

Expanding access to equitable "age in place" policies and programs requires well-trained, empowered navigators (e.g., caregiver consultants, case managers, and care coordinators). One of the primary training resources Minnesota makes available to navigators is the College of Direct Support. Program curricula include interdisciplinary web-based modules developed by the University of Minnesota Institute of Community Integration's Research and Training Center on Community Living. For nearly 20 years, the national College of Direct Support training platform has offered nationally validated, expert-reviewed training and professional development opportunities to direct support professionals and administrators. At present, in addition to direct support, course topics include person-centered counseling, personal assistance, and caregiving. Agencies have the option to customize the lessons to incorporate local resources.

For caregiver consultants specifically, certification from the MBA is predicated on successful completion of mandatory training on caregiver coaching skills and family meeting facilitation, among other topics. The ability to identify caregivers and provide equitable consultative services and supports to diverse populations requires familiarity with the impact of demographic identities (e.g., race, ethnicity, cultural beliefs, and primary language) and the intersection of those identities on access and service delivery outcomes.

As the older adult population in Minnesota continues to expand and diversify, community-informed refinements to caregiver consultant mandatory training requirements may ensure the continuity of inclusive, equitable services and supports statewide. Similarly, as the state considers next steps for implementing the MnCHOICES assessment tool and redesigning case management services and supports, DHS may have opportunities to refine equity-focused components of any required or optional training and professional development activity. Specifics on some opportunities related to standardized training for HCBS programs in scope of this research study are included in the Recommendations Section.

CONTEXTUALIZING RESEARCH FINDINGS: COMPARING MINNESOTA WITH OTHER STATES

Introduction

Minnesota is a recognized national leader when it comes to providing high-quality LTSS and HCBS. Various analyses highlight many of the state's strengths, including the LTSS Scorecard, National Core Indicators−Aging and Disabilities Survey, and the Medicaid LTSS Annual Expenditures Report. This section of the report identifies national benchmarks and compares Minnesota with other states through an environmental scan. These data help paint the picture of MN's programs that support caregivers, their families, and the aging population at-large.

When considering methods of reform, it is essential that we acknowledge Minnesota's current strengths, how the state compares with the rest of the nation, and opportunities for continued growth.

AARP LTSS Scorecard

The AARP LTSS Scorecard is a critical tool that informs key stakeholders and policymakers of the current health and functionality of LTSS systems in their state and helps benchmark the quality of services that support older adults, caregivers, and adults with disabilities.[34] The scorecard is divided into five dimensions: affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers, and effective transitions. For more than a decade, Minnesota has consistently ranked in the top two states on the LTSS Scorecard, emphasizing the strength and consistency of the HCBS and LTSS systems. In the most recent report (2019−2020), Minnesota ranked highest overall in the country, and first in two of the five dimensions—choice of setting and provider and quality of life and quality of care.

The scorecard provides relevant insights into the focus of this project, as it assesses the status of HCBS supports that play a significant role in the well-being of Minnesota caregivers. To support strong recommendations to enhance and reform the system, it is helpful to understand how Minnesota compares with the rest of the country, its strengths, and where it has opportunities to innovate. The scorecard provides a snapshot of information that can be used to reinforce and assess the system at a high level, which provides value to agencies working to enhance LTSS.

It is important to consider the impact that COVID-19 had on the data provided in the 2019−2020 scorecard; the results do not account for any pandemic-related measures that states enacted during this period because information about these initiatives had yet to be finalized and made available at the time the Scorecard data were compiled. [35]

In the Support for Family Caregivers dimension, MN ranked second in person- and family-centered care and first in nurse delegation and scope of practice. Table 19 illustrates how Minnesota's strengths in LTSS compare with other high-ranking states, including Washington, Wisconsin, California, and Massachusetts.

Table 19. Comparison of LTSS Among High-Ranking Scorecard States

State	Overall Ranking for LTSS	Support for Family Caregivers	Choice of Setting and Provider	Quality of Life and Quality of Care
MN	1	6	1	1
WA	2	2	6	27
WI	3	17	8	2
CA	9	8	2	24
MA	10	14	4	34

Though Minnesota's ranks sixth for support of family caregivers, it outranks Wisconsin (17th), California (8th), and Massachusetts (14th). Minnesota's scores on the AARP LTSS Scorecard for support of family caregivers improved in 2017−2020 as a total composite and on the dimensions of supporting working family caregivers and person- and family-centered

care but remained the same for nurse delegation and scope of practice and transportation policies, receiving a zero on both scorecards, as did nearly every other state. Minnesota's performance was generally consistent with the overall trends for all states, including significant improvements in person- and family-centered care and supporting working family caregivers and modest improvements in transportation policies. Among the five states in the comparison table above, all but California saw improvements in supporting working family caregivers. Aside from Minnesota, only Wisconsin demonstrated improvements in person- and family-centered care and nurse delegation and scope of practice.

National Core Indicators

The National Core Indicators−Aging and Disabilities (NCI−AD) project assesses programs that serve older adults and people with physical disabilities to better understand their quality of life and outcomes. The primary goal is to set clear performance standards for state entities to use in their analysis, reporting, and improvement of AD programs. The NCI−AD Adult Consumer Survey was piloted in early 2014, with Minnesota as one of three participating states. The program officially launched in 2015 with 13 participating states. Minnesota has participated in the survey ever since, with the exception of the NCI-AD Remote Survey Pilot Report in 2019−2020.

Minnesota surveys older adults every other year for NCI; 2017−2018 data were the most recent available for this analysis.[36] Minnesota collected 3,758 responses and included an aging subsample of participants (ages 65 and older) from the AC, EW, and State Plan Funded Home Care (HC) programs. Of the 3,758 responses, approximately 55 percent were from people in the aging subsample. The survey examines 18 domains, each of which comprises core indicators. Some of the domains and indicators that are most relevant to caregivers and HCBS within the AC and EW programs are listed in Table 20 and include Minnesota's results for each, as well as how the state compares with the NCI-AD average.

Minnesota consistently maintains scores that exceed or are aligned closely with NCI−AD averages, which speaks to the strength, quality, and consistency of MN HCBS and caregiver services for its aging population. Cross-state comparison is impossible in this analysis because each state has varying program structures and eligible participants. Consequently, HMA has compared Minnesota's scores with the NCI−AD Aging Average score as a form of reference.

Table 20. Minnesota Caregiver Programs Scores for Core Indicators

Core Indicator	MN Score (AC)	MN Score (EW)	NCI–AD Aging Average
Proportion of people who know whom to contact if they want to make changes to services	87%	73%	74%
Proportion of people who can reach their case manager/care coordinator when they need to	86%	86%	86%
Proportion of people whose services meet all their needs and goals	71%	77%	77%
Proportion of people whose family member (paid or unpaid) is the person who helps them most often (if someone provides support on a regular basis)	40%	41%	42%
Proportion of people who have transportation to get to medical appointments when needed	87%	95%	95%
Proportion of people who need a walker but do not have one	3%	2%	2%
Proportion of people who feel safe around their paid support staff	98%	97%	97%
Proportion of people needing at least some assistance with self-care who always get enough of that assistance when they need it	84%	86%	89%

The greatest difference in scores between AC and EW appear in three categories:

- Proportion of people who know whom to contact if they want to amend services
- Proportion of people whose services meet all their needs and goals
- Proportion of people who have transportation to get to medical appointments when they need to

Given the more limited benefit set in AC, a lower score on services to meet needs and having transportation is unsurprising. Less clear is the source of the disparity in percentage of people who know whom to contact if they want to update services, but it is relevant to the focus of this study regarding awareness and navigation of key supports for older adults and their caregivers (see Table 20).

Medicaid LTSS Annual Expenditures Report

Another valuable source of information is the Medicaid Long-Term Services and Supports Annual Expenditures Report,[37] released by the Centers for Medicare & Medicaid Services (CMS). This report outlines LTSS and HCBS expenditures across states and various service categories, pulling most of the data from CMS-64 reports. Data gathered provides insight into the use of LTSS and HCBS and can vary based on the demographics across the state and LTSS eligibility requirements (see Figure 34).

Overall, Minnesota spends more on LTSS and HCBS as a portion of its Medicaid expenditures than the rest of the country. Though the report does not illustrate use of HCBS and LTSS in the state, the high rates of expenditures highlight Minnesota's prioritization of allocating resources to these programs. Below are some key data points from the report, along with comparisons to Washington, Wisconsin, and Massachusetts. (California is excluded in the report analysis due to incomplete data)

In terms of Medicaid LTSS expenditures per state resident (FY 2019), Minnesota ranks third nationally and first when compared to Washington, Wisconsin, and Massachusetts.

- MN: $1,099.01 per state resident
- MA: $1,000.54 per state resident
- WI: $724.01 per state resident
- WA: $512.11 per state resident

In terms of Medicaid LTSS expenditures as a percentage of total Medicaid expenditures, Minnesota ranks fourth nationally and first when compared to Washington, Wisconsin, and Massachusetts.

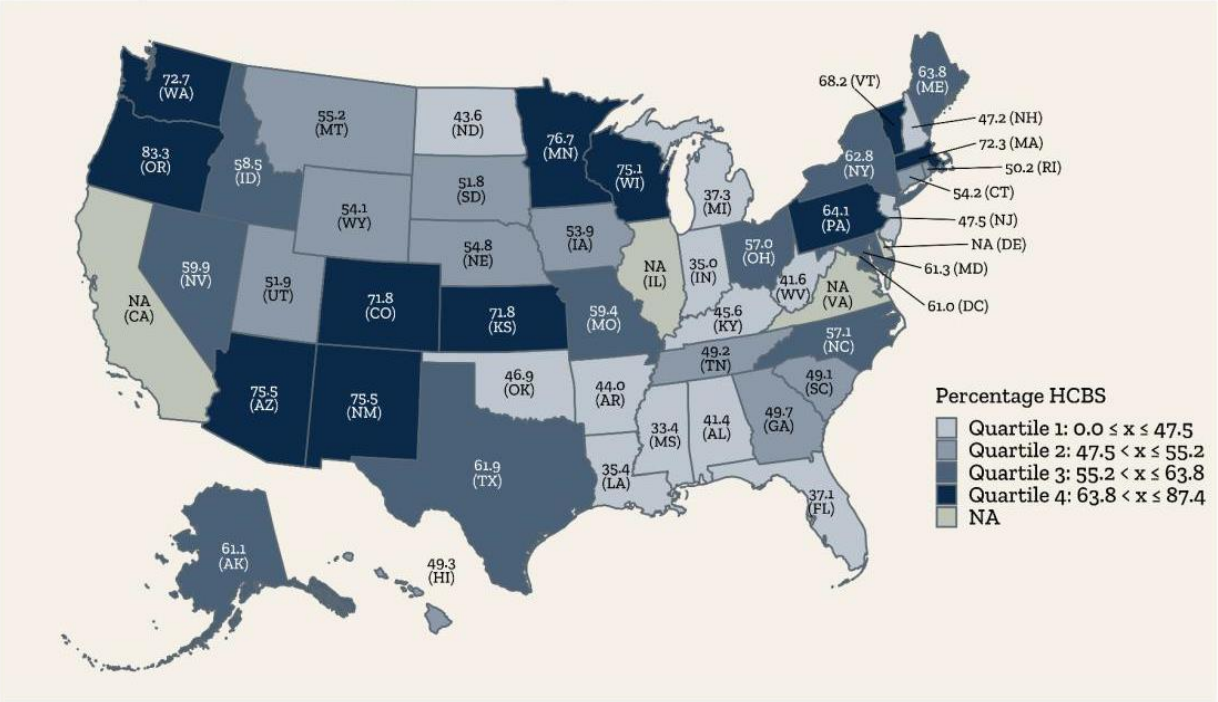
- MN: 49%
- WI: 46%
- MA: 40%
- WA: 30%

In terms of Medicaid HCBS expenditures as a percentage of total Medicaid LTSS expenditures, Minnesota ranks second nationally and first when compared to Washington, Wisconsin, and Massachusetts.

- MN: 77%
- WI: 75%
- WA: 73%
- MA: 72%

Over the past few decades, the portion of national Medicaid expenditures dedicated to LTSS have declined: 47 percent in FY 1988 to 34 percent in FY 2019. This decline can be attributed to states prioritizing HCBS funding, which is often more affordable and reaches a greater population of eligible recipients.

Figure 34. State Medicaid HCBS Expenditures as a Percentage of Total LTSS Spending, FY 2019[18]



BEST PRACTICES REGARDING CAREGIVER SUPPORTS

To determine whether Minnesota's family caregiver support programs meet established national standards, it is helpful to compare them with best and promising practices identified in the Administration for Community Living's 2022 National Strategy to Support Family Caregivers (National Strategy) and other policy overviews. Those practices can be grouped into several categories: family caregiver awareness, identification, and engagement; family caregiver screening/assessment and risk stratification; and measurement-based family caregiver support services.

Family Caregiver Awareness, Identification, and Engagement

A 2001 AARP Caregiver Identification Study[19] found that only 19 percent of individuals engaged in caregiving activities self-identified as family caregivers, and 15 percent of individuals who were engaged in caregiving activities did not consider themselves family caregivers. A 2007 study of caregiver self-identification[20] concluded that "affiliating oneself as a family caregiver appears to have positive benefits, which include promoting effective use of community support services." To better sustain caregivers in effectively supporting older adults, it is essential to normalize the caregiving role for them, help them self-identify as family caregivers, and thereby decrease any reluctance to use caregiver support services.

Public Awareness Campaigns

Public awareness campaigns can help family members identify as caregivers earlier in the process and mitigate their reluctance to engage with available support.

Hence, the first of the five overarching goals of the National Strategy is to "increase awareness of and outreach to family caregivers." In recent years, several states (e.g., DE, MD, MN, NJ, NY, TX, WA) have launched public awareness campaigns that encourage family members caring for older adults to self-identify as caregivers. Some states (e.g., IN, NJ, NY) have conducted family caregiver surveys or public listening sessions to gather information about caregivers' experiences and needs, which also serve to increase public awareness about the challenges of family caregiving.

Another approach some states (e.g., MA, IL) and counties (e.g., Santa Barbara County, CA) are using to increase caregiver awareness, identification, and engagement is the establishment of cross-sector caregiver coalitions, usually consisting of representatives from public agencies (e.g., AAAs, Departments of Human Services or Aging), healthcare systems, CBOs (e.g., aging-related service providers), and advocacy groups (e.g., the Alzheimer's Association). Coalition members collectively generate ideas for increasing caregiver support, collaborate on implementing new programs, and coordinate efforts for outreach to family caregivers. For example, from 2016 to 2022 the Santa Barbara Community Caregiving Initiative, with funding from the Santa Barbara Foundation, brought together 31 county and CBO partners, each of which promoted caregiver awareness and engagement to their respective constituencies.

Healthcare and Non-Medical Support Outreach

Because older adults frequently need healthcare and non-medical support, it is often within those healthcare settings—hospitals, palliative and hospice care programs, non-medical personal care, geriatrics and physical medicine and rehabilitation care, and disabilities services planning—that family members are identified and engaged as caregivers.

For example, Rush University Medical Center in Chicago created the Rush Caring for the Caregiver model, which Rush's primary care network and six other age-friendly health systems use to identify caregivers who are at high risk for burnout.[21] Some health systems (e.g., Dignity Health in CA, Department of Veterans Affairs) and CBOs enlist community health workers (CHWs)/*promotoras*, peers, or volunteers (e.g., Community Care Corps) to reach out to caregivers in their communities to connect them with their older adults' systems of care.

Many states have adopted legal and regulatory means of increasing caregiver awareness, identification, and engagement within care delivery systems. For example, 45 states, including Minnesota, have enacted the CARE Act, which requires hospitals to record the name of a patient's family caregiver in the medical chart, notify that family caregiver about the timing of the patient's discharge, and provide training to the caregiver on medical tasks, such as managing medications, which are needed for recovery at home. The law places the onus on hospitals to identify, engage, and support patients' family members as essential caregivers to improve care transitions from hospital to home and help decrease post-discharge medical complications and consequent readmissions.

Engaging through MLTSS and/or D-SNP

Some states are moving toward a distinctly focused caregiver identification and engagement model as a central feature of their Managed Long-Term Services and Supports (MLTSS) and/or Dual Eligible Special Needs Plan (D-SNP) programs. For instance, Indiana's managed LTSS program, slated to begin in 2024, will require MLTSS insurers to identify and assess their beneficiaries' family caregivers. Caregivers who are evaluated to be at high risk will be directed to caregiver support services and offered a coach who can support and represent caregivers in the care team function and help caregivers navigate the MLTSS program overall. It will be a requirement that caregivers have consistent and meaningful engagement as members of beneficiaries' healthcare team.

How Minnesota Compares

In 2011, the St. Paul-based Amherst H. Wilder Foundation, with funding primarily provided through a partnership with the Schultz Family Foundation and the State of Minnesota DHS Live Well at Home program, launched a five-year, multi-pronged project to increase caregiver identification, develop new caregiver support services, and activate caregivers to use those services. The first component of this project, the Caregiver Awareness Campaign, had four waves of digital and traditional media messaging about family caregiving to help caregivers self-identify. As part of the second component, the Wilder Foundation created a website to direct caregivers toward community resources, including the Senior LinkAge Line, a single point of access for information for caregivers still in use by the Minnesota Board on Aging, and www.Minnesota.Help.info to provide information about human services in the state. Since the Wilder Foundation project's final report in 2016, Minnesota has been without a public awareness campaign targeted at caregivers.

The Minnesota Caregiver Coalition has identified caregiver awareness as a priority issue in the near future.

Annual MN Caregiver Surveys were initiated in 2002 to assess whether caregivers receiving OAA services perceived improvements in care. The survey is administered to people receiving caregiver support services, and the responses are analyzed to drive program quality enhancements.

The MN OAA caregiver consultants identify and engage caregivers who qualify for services through several possible means, including caregiver engagement in community programs, such as home-delivered meal providers, and facilities, such as skilled nursing facilities, transitional care units, and continuing care retirement communities. HMA recommends that the possibility of enhancing proactive, upstream OAA (AAA) outreach to caregivers to increase awareness, identification, and engagement be further explored.

AC and EW caregiver identification and engagement efforts occur in the context of the case management for older adults whom caregivers support. Opportunities exist to improve caregiver engagement in support services through this case management function.

As noted above, Minnesota passed the Care Act, but it is unclear whether the OAA, AC, and EW programs support hospitals in identifying and training patient family members in home-based caregiving tasks to prevent readmissions.

Family Caregiver Screening/Assessment and Risk Stratification

The National Strategy's second goal of advancing partnerships and engagements with family caregivers includes Outcome 2.2, which states, "Where appropriate, identifying services and supports needs for caregivers consistently starts with a review of family caregiver strengths and preferences using evidence-based assessments."

In addition to strengths and preferences, nearly all caregiver assessments evaluate caregiver burden (i.e., level of coping) to predict which caregivers are at risk for burnout, depression, and other forms of morbidity and their need for more intensive assistance. The Family Caregiver Alliance (FCA), a national caregiver advocacy group, has identified seven domains of caregiver assessment:[22]

- Background on the caregiver and the caregiving situation
- Caregiver's perception of health and functional status of the care recipient
- Caregiver's values and preferences
- Health and well-being of the caregiver
- Consequences of caregiving on the caregiver
- Care provision requirements (skills, abilities, and knowledge)
- Resources to support the caregiver

Other common variables for assessment include the caregiver's willingness and availability to provide needed care and the stage (early, mid, late) of caregiving (both possibly encompassed by the first variable above), as well as their willingness to use caregiver supports. The Caregiving in the US 2020 report[23] and other sources suggest additional factors put caregivers at risk and should be considered in caregiver assessments:

- Caregivers who are highly stressed while assisting participants with moderate to severe dementia who need help with ADL and mental activities of daily living (IADLs)[24] or have behavioral disturbance (e.g., agitation, aggression)[25 26].
- Caregivers who provide 40 or more hours of care per week[27]
- Elderly spousal caregivers living with clients[28]

- Caregivers who feel socially isolated and lonely[29]
- People who feel they have “no choice” but to be a family caregiver[30] [31]
- Caregivers who identify as LGBTQ+[32]

Despite general agreement on these domains, states take different approaches to caregiver assessment, use different tools (e.g., Administration of Community Living, 2016[33]) and use the test data differently:

- Some use evidence-based tools (e.g., Zarit Caregiver Burden Inventory, TCARE ASSIST). Others create their own instruments or use tools with limited validation.
- Some have separate caregiver screeners or assessments that are administered universally to specific populations (e.g., LTSS, D-SNP). Others have a few caregiver-related questions and longer caregiver modules that are used optionally as part of comprehensive client assessments (e.g., InterRai).
- Some use initial assessment data to formally quantify a caregiver’s degree of burden to stratify caregivers who could benefit from a higher level of support services. Others use the initial data in more informal, impressionistic ways to assist service planning.
- Some states (e.g., Washington) also use aggregated, serial caregiver assessment data to measure the efficacy of their program’s caregiver support services in decreasing caregiver burden and thereby reducing the rate of participant institutionalization. This methodology provides a basis for calculating ROI for their caregiver support programs.

How Minnesota Compares

MN’s AC, EW, and OAA use different caregiver assessment instruments that measure somewhat differing variables. They also focus to varying extents on evaluating either the caregiver’s status or the caregiver’s perceptions of the participant’s status. Hence, it is difficult to compare and aggregate the results gathered for the three programs.

Under Minnesota's OAA program, caregiver consultants are trained in the Family Caregiver Alliance's (FCA) seven domains of caregiver assessment, as well as family dynamics, cultural factors, and other variables that affect caregiving. Caregiver Consultants use a brief assessment to collect information on both the caregiver's status and the caregiver's perception of the participant's status. It comprises a caregiving questionnaire to gather information about the participant's ADL, a 20-item evidence-based caregiver screening, the evidence-based Center for Epidemiologic Studies Depression Scale (CES-D), and more, including the seven-item Live Well at Home Rapid Screen−Family Caregiver test.

The TCARE ASSIST screening evaluates the background of the caregiver and the caregiving situation, the health and well-being of the caregiver, and the consequences of caregiving. It also has several questions about the caregiver's "identity discrepancy" (i.e., their challenges with adopting to their caregiving role and balancing it with other life roles) and whether they have a sense of purpose and gratitude as a caregiver. Of note, while the CES-D, first published in 1977, is a reliable and valid tool, it is no longer widely used and has been supplanted by other evidence-based depression screening instruments, mostly the Patient Health Questionnaire-9 (PHQ-9).

DHS's 2019 Title III (OAA) Caregiver Survey asked about several important variables of caregiver assessment, including number of hours per week of caregiving, availability of family and social support with caregiving tasks, participant's cognitive status, and caregiver self-reported outcomes of supportive services. The information collected, however, is used for program evaluation, not individual caregiver assessment and risk stratification.

Under its AC program, all family caregivers present during the MnCHOICES assessment of the older adult are administered the 16-item MnCHOICES Caregiver Module, largely focused on the caregiver's perceptions of the participant's needs. It is used to evaluate the caregiver and the caregiving situation, including cohabitation, evidence of cognitive impairment, and the number of caregiving hours per week; the caregivers' perceptions of the care recipient's health and functional status; the health and well-being of the caregiver; and resources to support the caregiver.

In the EW program, participants who appear to need waiver services are administered the LTCC 3428. If the caregiver is present during that assessment, then the 13-item Informal Caregiver Assessment of the LTCC 3428, largely focused on the caregiver's status, is used to evaluate the caregiver. If the caregiver is absent during the assessment, the best practice is to follow up to engage the caregiver. The tool has questions about the caregiver's

background and the caregiving situation, the health and well-being of the caregiver, consequences of caregiving on the caregiver, and resources to support the caregiver.

There is little formal tracking over time of caregiver outcomes. Although assessors in EW and AC should review a caregiver's last assessment before completing a reassessment, it is unknown how consistently this activity occurs. There is no consistent, reportable tracking of the reevaluation or change in caregiver status at this time.

Family Caregiver Services

According to the National Strategy, state or regional caregiver service delivery systems should offer services that are easily accessible, have a single point of entry, and be linguistically and culturally intentional.

Services should be available by multiple means, including in-person and online, to better meet the needs of busy caregivers. Other best practices include the following service categories:

Education

Many existing resources are available to educate caregivers about their roles and responsibilities. Most cover basic topics: orientation to caregiving; normal emotional reactions to caregiving, signs of stress/burnout, and stress management; how to partner with an older adult's healthcare and social services providers; and information about an older adult's conditions and treatments. Curricula sometimes also include tips on managing difficult relationships with older adults and family members.

Training

Most caregiver support programs include access to specific skills training, such as assisting the older adult with ADL (e.g., bathing/showering techniques, appropriately helping with ambulation and transfers) and IADL (e.g., managing medications, handling finances). Additional training areas might include managing difficult dementia-related behaviors (e.g., agitation), specific healthcare skills (e.g., flushing a feeding tube, monitoring equipment), and convening a family meeting.

Emotional and logistical support

This broad category includes a range of supports to help caregivers sustain their well-being while caring for an older adult over months and years. These supports are listed below from those that are most to least common among caregiver programs:

- Guidance/navigation regarding the care delivery system and available resources
- Instruction in self-care activities to decrease stress, which may include directing caregivers to online apps and other tools.
- In-person or online caregiver support groups
- Referral to behavioral health services, including medication therapy and individual/family therapy
- Respite care
- Volunteers, peers, and/or CHWs to assist with navigation and emotional support

Financial support

According to recent estimates, family caregivers incur more than $7,000 in out-of-pocket caregiving-related expenses annually.[34] Depending on the state and county, caregiver support programs will reimburse some expenses that are directly used to support aging in place, and the amount of a monthly cap varies greatly.

Measuring outcomes

Most states measure caregiver satisfaction with caregiver support services, but according to a December 2022 brief from the National Academy for State Health Policy[35], "very few states have consistently measured family caregiver outcomes" such as the impact of those services on caregiver burden or LTSS costs. An exception has been the state of Washington. Under an 1115 Medicaid waiver, Washington evaluates the efficacy of its caregiver support services using three types of metrics:

1. Surveys and administrative self-reports measuring caregiver characteristics and condition/circumstances (e.g., caregiver burden, physical and mental health status, quality of life) and LTSS placement intention. The TCARE assessment system

captures much of this information.

2. Comparisons between Medicaid Alternative Care clients, who are eligible for caregiver assistance options, and recipients of traditional Medicaid LTSS services on health services utilization, as measured by ED visits and rates for inpatient admission and readmission, nursing facility placement, and mortality.
3. Overall LTSS utilization and cost impact estimates

How Minnesota Compares

Minnesota covers the cost of many services, including caregiver education, training, and emotional support (e.g., family caregiver coaching and counseling with assessment) as well as respite, provided by a range of professionals. For example, OAA has invested $1 million to increase respite services in 15 counties and has helped create a Train the Trainer program to prepare 20 respite volunteers in the other counties.

Minnesota has annual Live Well at Home grants, which are awarded to organizational applicants for various services, including increased support for older adults and their family caregivers to prevent LTSS placements. For example, a Live Well at Home grant partially funds the Program to Encourage Active and Rewarding Lives (PEARLS), a free counseling program for adults ages 65 and older with low mood or depression, developed at the University of Washington and provided through the OAA program by several AAAs and private, nonprofit CBOs in various regions of the state.

Minnesota does not offer a capped stipend to reimburse individual participants and their caregivers for expenses (e.g., home modifications, diapers) to foster aging in place.

As noted previously, DHS' 2019 Title III Caregiver Survey asks caregivers to indicate the number of hours per week they spend caregiving, the availability of family and social support with caregiving tasks, their participant's cognitive status, and outcomes of caregiver supportive services. The January 31, 2023, MBA Performance Measures Report, recommended three performance metrics for its Title III-E caregiver supportive services for use in its upcoming federal FFY 2024-2027 State Plan on Aging, including:

- Total number of caregivers receiving Title III-E services
- Level of caregiver satisfaction with caregiving supportive services they have received

- Self-reported outcomes of caregivers who have received caregiving supportive services

Summary

As the sixth ranked program nationally for Support for Family Caregivers in the 2020 AARP LTSS Scorecard, Minnesota caregiver supports have demonstrated strengths in the number of person- and family-centered caregiver service options offered. Areas for potential improvement include:

- Reinitiate an ongoing caregiver public awareness campaign to increase self-identification and use of support services.
- Adopt a uniform approach to evidence-based caregiver assessment across AC, EW, and OAA programs.
- As the 2020 AARP LTSS Scorecard suggests, “Conduct universal family caregiver assessments to determine which supports family caregivers need for their own health and well-being.” This approach differs from assessing caregivers on an as-needed basis. Administering a universal caregiver screening/assessment upon the older adult’s engagement with LTSS, might allow Minnesota programs to provide earlier interventions and produce better outcomes.
- Use assessments quantitatively to formally risk stratify caregivers to identify people who could benefit from more intensive support services.
- Track and aggregate serial caregiver assessment data to assess ROI in caregiver support services.
- Expand opportunities for respite and caregiver peer support programs.

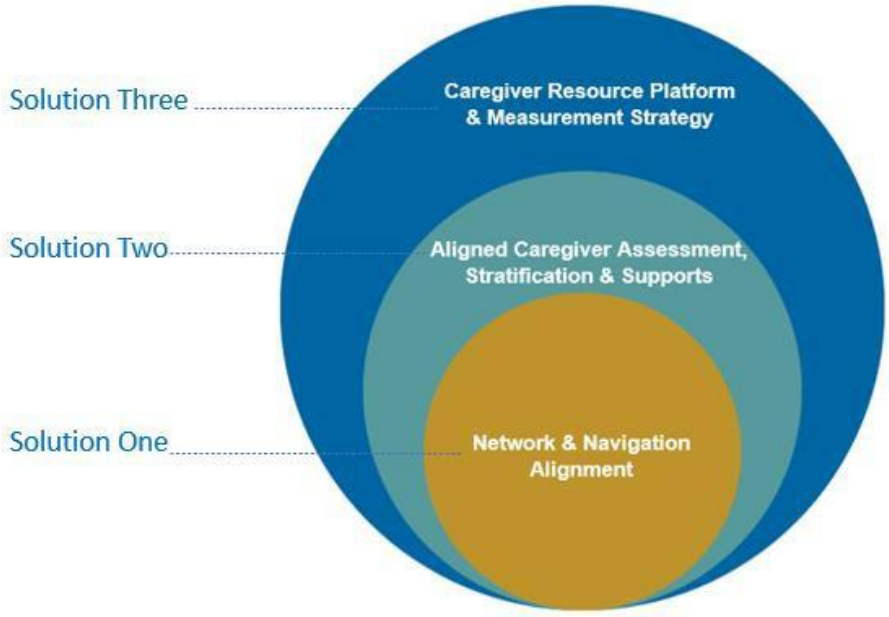
RECOMMENDATIONS

AARP studies suggest that nearly three-quarters of Americans would prefer to remain in their own homes as they age. Consequently, many of these individuals rely upon the hands-on, logistical, and emotional support of informal caregivers, including family members, friends, and neighbors. These caregivers, though, may experience duress and burnout eventually causing them to cease caregiving, and thereby increase the likelihood that their loved ones will spend their last years in institutions. To enable more older Minnesotans to age in place, therefore, the Minnesota DHS is seeking to bolster the resilience of informal caregivers by enhancing the accessibility and use of the state's caregiver support services.

In September 2022, DHS's Aging and Disability Services Administration (ADSA), contracted with HMA to study the accessibility of respite services and other caregiver supports under its HCBS system and increase accessibility in the future. DHS accepted HMA's proposal to focus its study on the caregiver supports available through three distinct Minnesota HCBS programs—AC, EW, and OAA. The three programs were conceived at different times, target slightly different populations, and receive funding from different sources within DHS's complex, matrixed structure. The result is a DHS caregiver support system that is innovative but complex, fragmented, and, in some respects, uncoordinated.

Our analysis suggests that creating greater alignment among the three programs will help Minnesota increase the state's informal caregivers' access to evidence-based services and supports and reduce burden on the program administrators. Aligning and improving these programs will affect other sectors of the HCBS system. As Minnesota's demography changes and its workforce continues to constrict, sustaining informal caregivers who support the state's growing number of older adults should be seen as a means of reducing current and anticipated workforce shortages.

Other initiatives are under way to improve Minnesota's HCBS system, including an assessment of HCBS rates, expansion of self-directed caregiver supports, alignment of caregiver support service descriptions and updates, analysis of assessment patterns and disparities, and evaluation of COVID's effects on the HCBS service system and workforce. We have consequently designed the recommendations below to avoid duplicating or complicating existing efforts. For a concise outline of the detailed recommendations below see Appendix A.



Recommendation One: HCBS Network Navigation and Service Alignment

Two key strategies could be applied to implement the first recommendation:

1. Improve HCBS provider network navigation
2. Align caregiver terms, services, and resources

Background

AC case managers, EW care coordinators, and OAA caregiver consultants face significant challenges in securing supports for older adults and their informal caregivers. One reason is that, as in many sectors of the post-pandemic US economy, the Minnesota HCBS workforce is shorthanded and strained. Another is that collecting and maintaining data on the state's HCBS provider network under current HCBS data requirements and systems can be complicated and costly, compounding the difficulties of finding providers of needed services for participants and their family members.

Two incongruent systems create challenges for program navigators, older adults, and Minnesotans in general. The state has a vast set of HCBS provider network information

available at www.MinnesotaHelp.info. Minnesota also is required to maintain a slightly different, DHS-enrolled HCBS provider network information, representing the Minnesota Health Care Program (MHCP) Provider Network.

Though MN DHS makes available a provider directory, including enrolled HCBS providers, and sends MCOs a monthly provider enrollment file, the MinnesotaHelp.info database, managed by OAA and MBA, is a primary resource for case managers and care coordinators. This database includes functionality to house provider information on provider specialization and geographic areas served. AAA staff update it by completing reviews and analyses of providers, supplemented by several other data sources (e.g., MDH licensing), at least once a year. Twice a year, the AAAs collaborate on data integrity projects with MinnesotaHelp.info. We learned through some of our SME interviews that it offers greater flexibility for making provider updates than the DHS Provider Enrollment. MinnesotaHelp.info also can connect with the MN DHS data warehouse to add HCBS providers from DHS monthly. The flexibility for updates and the enhanced search capabilities are attractive; however, HMA learned during the project research that MinnesotaHelp.info has limitations and instead decided to use DHS provider information.

Though some forums identify OAA/AAAs as the accountable entity for statewide LTSS network cultivation and updating the MinnesotaHelp.info database, they are not responsible for EW or AC network development, support, or management. LTSS providers interested in providing services to AC and EW programs have several pathways for enrollment and navigation, including DHS provider enrollment, county case management systems (AC), and potentially eight different Medicaid MCO EW provider network teams and claims processing centers.

EW care coordinators use various HCBS network resources, drawing upon the monthly files of all DHS-enrolled providers that the MCOs receive. Nonetheless, a disconnect may exist between EW and available HCBS providers of caregiver support services that limits the number of EW services provided. Previous provider surveys revealed several concerning findings. First, many providers are unaware that their caregiver services are billable to EW. Even if they do know, they lack education on billing EW for those services. They believe they need more support to enroll as Medicaid providers and information on the requirements for enrollment in EW networks. Addressing these concerns has been challenging because of the cross-functional nature of the EW program and network enrollment/management of HCBS services spanning multiple departments and divisions at DHS, which complicates identifying one owner of this work at DHS.

AC case managers have access to less information, often relying on county lists or The MHCP Provider Directory, which states it may not contain all HCBS providers and directs users to Minnesota.Help.info for more information.

Another key provider topic relates to which providers participate in all three programs. Providers may enroll through DHS Provider Enrollment to serve in the EW or AC programs, or they must contract with one of the MN AAAs for inclusion in the OAA HCBS provider network. HCBS provider network analysis identified a range of provider continuity across OAA and AC/EW programs ranging from 80−100 percent. The higher percentages support stronger continuity across programs and provider sustainability to leverage multiple funding sources. For providers not enrolled across all three programs, creating guides and tools as well as key supports to help providers may increase provider enrollment while decreasing HCBS provider administrative burden. Other strategies include telling providers that DHS would prefer that they serve all three programs or providing incentives to do so. Another possibility is that DHS could mandate that providers enroll in Medicaid if they serve OAA programs, as is required for Live Well at Home grant recipients.

Strategy One: Improve HCBS Provider Network Navigation

ACTION STEP ONE

DHS should improve the consistency and availability of network information for caregiver navigators and Minnesotans. Ideally, harmonized information would be provided across the DHS-enrolled providers (used to populate the MN DHS Provider Directory) and the MinnesotaHelp HCBS provider information. Complete alignment may not be feasible due to regulatory requirements limiting how provider data is updated by DHS that MinnesotaHelp.info does not need to adhere to. Additionally, MinnesotaHelp.Info undergoes different data integrity steps and has more flexibility to update provider data elements than MN DHS. Systems and data transition work create other barriers to data consistency. Given these realities, the following action steps are recommended to improve the state of HCBS provider data across these two data systems:

- Improve the alignment of MHCP Provider Directory, MCO PECD file, and MinnesotaHelp.info. data

- Train AC case managers and EW care coordinators on which platform they should consult for each type of needed services to reduce their administrative burden when seeking appropriate providers.
- Prioritize key data elements each system offers. For example, invest in MinnesotaHelp.info to gather and make publicly available HCBS provider information about language/cultural expertise and service area. Clearly map out for Minnesotans, AC case managers, and EW care coordinators which source to use for specific types of information.

ACTION STEP TWO

- Require MCOs to have specific online tools and resources available for HCBS providers on how to participate in the MCO HCBS network, bill for HCBS services, and efficiently resolve payment issues. As MLTSS programs have become more common, states are increasingly looking for MCO partners to provide additional support to Minnesota's HCBS provider network, which is struggling to maintain businesses, attract workers, and meet new regulations. Although Minnesota is fortunate to have longstanding MLTSS health plans that administer EW, HCBS providers need to interface with eight different plans when serving as EW program participants. Feedback from the caregiver provider network gathered for the Minnesota Caregiver Supports Improvement Plan underscored the need for additional provider education, support, and awareness about working with all MN EW MCOs.

ACTION STEP THREE

- Invest in training of AAA Elder Development Planners (EDPs) so they can support caregiver and HCBS providers when they encounter challenges in the HCBS system (including in EW and AC).
- HCBS providers interested in serving older adults and caregivers in AC, EW, and OAA programs must follow different procedures for provider enrollment, service authorization, and billing. A uniform set of procedures is lacking, and no single entity can provide guidance across the three programs. The AAA EDP staff are well-positioned to expand their expertise and provide the necessary support and navigation. At minimum, EDP staff should have annual training about EW and AC so they can answer basic questions about all three programs from HCBS providers and direct them to the appropriate resources.

Background: Alignment of Caregiver Terms, Services and Resources

One contributing factor affecting alignment across the three caregiver support programs is that each defines "caregiver" differently, creating confusion among older adults, caregivers, HCBS providers, case managers, care coordinators, and caregiver consultants. Caregivers are sometimes described in terms of regulatory requirements (OAA definition) or system or assessment requirements and rules (MnCHOICES). Its definition is simplified based on the audience (e.g., on Senior Linkage Line and the Minnesota Board on Aging website). In some instances, the definition may be missing from key regulatory resources (MN DHS MCO Seniors Contracts). Opportunities to align definitions and reduce confusion while increase collaboration and coordination across programs are worth exploring.

Also apparent is limited awareness about caregiver supports services. For example, prior research[36] surveyed all MCO EW care coordinators about EW caregiver support services. Among those surveyed were county staff who wear multiple hats as EW care coordinators and AC case managers. More than half of these individuals expressed a need for clarification of what caregiver support services were, despite the services being available on the waiver menu. Furthermore, 20 percent of the care coordinators said they don't send referrals for caregiver supports and more caregiver providers need to participate in the program.

As mentioned previously, DHS is working to align service descriptions, which is necessary and advisable. Whatever service descriptions are devised should be clearly and consistently communicated across AC, EW, and OAA programs. SMEs interviewed during the HMA project commented on the ongoing staffing succession in recent years among the AC case manager and EW care coordinator workforces, resulting in a greater need for training. One AC case manager said that written information, such as a MCHP Provider Update, helps but ongoing training is needed "for the information to really stick."

Although caregiver support services are similar across programs, AC case managers and EW care coordinators appear to have limited awareness of each other's programs or the OAA caregiver support program, and they have few requirements for referring to them. The reality is that the three programs likely serve the same subpopulation of older adults and their caregivers over time, but case managers and care coordinators only share information about their specific program's supports and services rather than providing a broad overview of the whole DHS caregiver support system. It is unknown whether OAA caregiver consultants know about the HCBS services available in AC and EW, as it seems that coordination with case managers and care coordinators infrequently occurs. The entire system could benefit from cross-pollination of information, resources, and best practices.

For example, the OAA has a caregiver education and support platform that is available to informal caregivers. This platform would assist more Minnesota caregivers if it also were available to caregivers identified in the AC and EW programs. Older adults and their caregivers would be better supported, providers would likely encounter less administrative burden, and program and other resources would be better known to case managers, care coordinators, and caregiver consultants across all three programs.

Strategy Two: Alignment of Caregiver Terms, Services and Resources

ACTION STEP ONE

› Pursue alignment in caregiver terminology and increased awareness of caregiver support services across AC, EW, and OAA programs.

ACTION STEP TWO

- Develop a universal referral form that AC, EW, and OAA programs can use to make referrals for caregiver consultants, respite, caregiver coaching and counseling, and caregiver training and education services to increase systemic awareness, support warm handoffs, and ease the administrative burden for providers who serve all programs.

ACTION STEP THREE

Implement caregiver navigator and community-focused forums to support improved awareness, alignment, and sharing of best practices. Implement a DHS-sponsored caregiver collaborative learning series to discuss caregiver challenges (e.g., service training, best practices, provider success or innovation stories, grantee offerings, external resources, supplemental benefits, use of caregiver education platforms, dementia grantee efforts, etc.).

- Implement a quarterly DHS-supported caregiver navigators' best practices workgroup that includes AC, EW, and OAA caregiver support service representatives and the caregiver consultant workforce.
- We recommend that this workgroup select a planning group that includes one representative from each of the programs to support DHS in planning the agenda and recruiting workgroup participants.
- An AC case manager interviewed for this project suggested modeling this panel on an existing CDCS workgroup. Agenda topics should include sharing information about programs offerings, resources typically used, case examples, lessons learned, and best practices. An intentional agenda with strong engagement from representatives across all three programs is essential to the success of the workgroup.

ACTION STEP FOUR

› Remove access barriers to caregiver education and support platforms in OAA programs and make those platforms available to caregivers identified in AC and EW programs.

Recommendation Two: Enhanced Caregiver Support through Strengthened Identification of Needs and Caregiver Support Planning

DHS's caregiver support services have many effective elements, but they need to be applied consistently across the AC, EW, and OAA programs. After studying the services available to participants and family caregivers, HMA concluded that the OAA program has two distinct components—increased expertise and a designated caregiver focus--that would be invaluable to participants in the AC and EW programs.

OAA caregiver consultants receive more training and develop greater caregiving expertise than most AC case managers or EW care coordinators. Rather than focusing on caregiver needs in the context of participants' care plans, caregiver consultants primarily focus on the caregivers. Given the benefits of the OAA program, HMA recommends that all caregivers of participants across the OAA, AC, and EW programs, be evaluated by the caregiver consultants using a uniform set of screeners/assessment tools and procedures.

We also suggest expanding the required roles of caregiver consultants to include close collaboration with applicable entities that authorize care recipient supports, which may also provide relief to caregivers (i.e., partnering with AC case managers and EW care coordinators and referrals to AAAs).

This second recommendation would involve three key strategies:

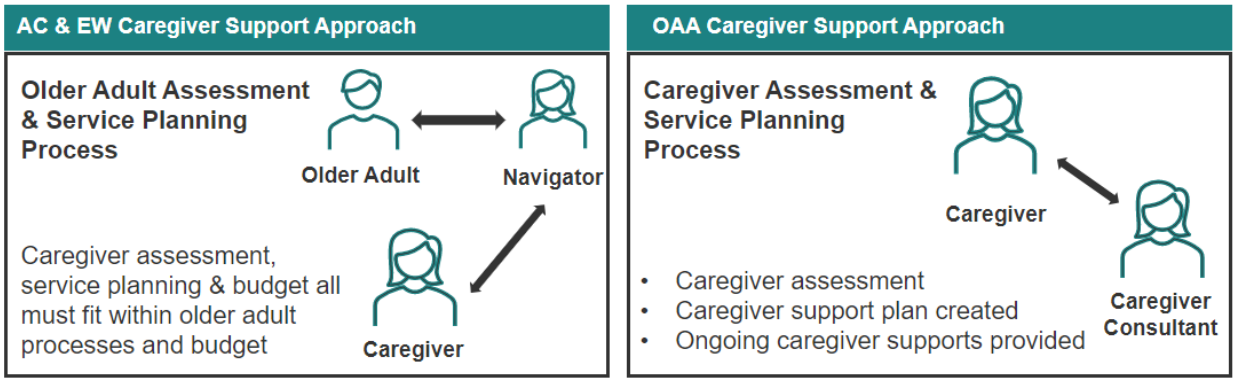
1. Increase referrals to caregiver consultants from intake workers and case managers in the AC, EW and OAA programs
2. All identified caregivers in AC, EW, and OAA programs should have individualized attention with a designated caregiver focus

3. Cultivate deeper caregiving expertise across AC, EW, and OAA programs to increase the capacity of workforce to address caregiver needs with a focus on equity

Background: Need for Caregivers to Have Individualized Attention and Focus

Caregiver identification, needs assessment, and follow-up support planning occur in two different ways across the three programs. AC and EW have similar processes in which the caregiver is engaged as an extension of the eligibility and processes focused on the care recipient/older adult who qualifies for AC or EW. In OAA-funded caregiver support programs, caregivers are engaged because they are caregivers, regardless of the care recipient's program eligibility or activity.

Differences in approach are outlined in detail in the Programs in Scope Operational Alignment section of this report and illustrated in the following figure.



Both approaches have strengths and weaknesses. The strengths of the current AC and EW model include:

- Consistent, mostly proactive approach to identification and assessment of caregivers
- Comprehensive assessment and service planning with all benefits in one care and service plan
- One consistent contact to address service needs or challenges across the entire care plan

The strengths of the OAA model include:

- Deliberate, individualized focus on caregiver experience and needs
- Assessment tools that are evidence-based and relatively comprehensive
- Enhanced training about caregiver issues is required of all caregiver consultants
- Support plan and funds for services are focused on caregiver needs
- Assessment when the caregiver needs it and is available

The potential positive effects of an intentional, evidence-based caregiver assessment of caregivers' specific needs are many. Assessment helps increase caregiver self-identification and awareness of caregiving's challenges. One of the strongest elements of the AC and EW process is the consistent approach to identifying caregivers. These programs also benefit from integrated services planning to meet both the older adult's needs and provide caregiver support. The reality, however, is that the chief priority of AC case managers and EW care coordinators is the older adult. Consequently, the older adult's caregiver may get too little attention or support. HMA's data analysis of DHS caregiver support programs shows minimal payments for AC and EW caregiver support services, suggesting that AC case managers and EW care coordinators may be so busy addressing participants' needs that they cannot adequately address those of caregivers.

In the OAA program, caregivers receive caregiver-focused assessments and supports from a caregiver consultant who focuses only on the caregiver's needs and experience. The OAA model offers the benefit of full attention to the caregiver, though it has limitations in the scope of benefit coverage that the caregiver consultant can authorize, thus limiting supports offered in the overall service plan. Another limitation of OAA's approach is that caregiver engagement typically occurs only when a caregiver consultant encounters a caregiver where the caregiver consultant is located (e.g., a nursing home). Building in more proactive caregiver identification and referrals through OAA programs such as Senior Linkage Line and Return to the Community interactions would result in more caregiver engagement, assessment, and support.

One of the most highly regarded caregiver support programs in the nation is Washington State's. Its model includes universal screening of the caregivers of all participants, uniform caregiver screener/assessment tools and procedures, consistent collection of

screener/assessment and intervention outcome data, caregiver-specific service planning and resources, and regular training of the individuals who conduct the uniform caregiver assessments. Washington uses the TCARE assessment system, an evidence-based suite of vendor-created and managed products to measure and analyze the ROI of its caregiver support programs. Minnesota does not offer the same degree of consistency in its caregiver assessment procedures and consequently is less equipped to measure outcomes or ROI for the caregiver supports provided through its AC, EW, and OAA programs.

Strategy One: Increase Referrals to Caregiver Consultants Across AC, EW, and OAA

ACTION STEP ONE

- Require AC case managers and EW care coordinators to refer identified caregivers to a caregiver consultant, with permission from the older adult or caregiver. This action would result in the caregiver consultant doing separate outreach to the identified caregiver after the AC case manager or EW care coordinator has completed the LTCC/MnCHOICES and made a referral to a caregiver consultant. Consequently, case managers and care coordinators would no longer conduct caregiver assessments as part of the LTCC/MnCHOICES. This action step may need to be phased in iteratively to address caregiver consultant workforce capacity as well take into consideration other large-scale initiatives that may have impact, such as MnCHOICES implementation.

ACTION STEP TWO

› Revise strategies that AAA and Senior Linkage Line program staff use to proactively engage participants' family caregivers and refer them to caregiver consultants. At present, most OAA caregiver consultant services result from consultant engagement, not referrals from AAAs or the Senior Linkage Line.

Strategy Two: Identified caregivers across AC, EW, and OAA programs will have individualized attention and service planning from caregiver consultants

ACTION STEP ONE

› Use the evidence-based caregiver consultant assessment tool and support planning approach for all caregivers who are engaged across the AC, EW, and OAA programs. This system builds upon the Action Step under Strategy One, which suggests that AC case managers and EW care coordinators refer all identified caregivers to consultants for outreach and follow-up. Upon receiving a referral, the caregiver consultant would apply the same approach to screening/assessment, risk stratification, and service planning for caregivers across all three programs.

ACTION STEP TWO

- Develop a model training curriculum for caregiver consultants to enhance their skills when working across all three programs, including training on culturally and linguistically appropriate services (CLAS) standards and equity.
- The 15 national CLAS standards in Appendix E are valid measures for individuals and systems to benchmark performance and assess the degree to which structures, policies, and practices are responsive to diverse health beliefs, practices, and needs across diverse populations. Building on the state's current staff training and evaluation processes, incorporating a CLAS standards assessment into the caregiver consultant model training curriculum affords DHS an opportunity to ascertain caregiver consultants' knowledge and use of the CLAS standards in their engagements.

ACTION STEP THREE

- Develop a model training curriculum for AC case managers and EW care coordinators on the role of the caregiver consultant and best means of referring/collaborating to provide effective caregiver assessment, care planning, and supports. Leverage the training opportunity to include content on CLAS standards and equity.
- Building on Action Step Two, the model training curriculum for AC case managers and new care coordinators would include the national CLAS standards.

ACTION STEP FOUR

› Establish orientation and annual trainings to enhance fidelity to best practices.

ACTION STEP FIVE

› Create regular “office hours” with experienced caregiver consultants who can provide timely consultation to AC, EW, and OAA staff about caregiver needs.

Recommendation Three: Statewide Caregiver Resource Platform and Measurement Strategy

The third recommendation encompasses two key approaches:

1. Increase the availability of a statewide caregiver resource platform to people in the AC, EW, and OAA programs
2. Implement a statewide caregiver support measurement strategy

Background: Statewide Resource Platform

Readily available, up-to-date, and community-specific information is vital to effectively support caregivers. How AC case managers, EW care coordinators, and caregiver consultants find information to make effective and timely referrals—including to supports outside of the AC, EW and OAA benefit sets—greatly affects the likelihood that caregivers will use recommended services. AC, EW, and OAA programs do not use the same source of information to meet caregiver needs for resources needs beyond publicly funded

services and supports. Having a statewide, designated caregiver resource platform offering community-specific resources and caregiver educational material would help decrease variability across the programs in support and resource access potential. For example, Washington State uses an automated caregiver platform as its single resource authority, and Michigan is considering devising its own statewide caregiver resource platform.

OAA has implemented a caregiver education and support platform that AAAs use, which houses an extensive library of written, audio, and video materials on various topics, such as specific diseases (e.g., dementia, Parkinson's disease) and their treatments and caregiving/self-care skills, (e.g., stress management, assisting with transfers, managing medications). The functionality of this platform could be enhanced to make it a full-fledged caregiver resource platform by adding several additional features:

1. Community-specific resources and educational content made available in different languages (e.g., Hmong, Somali, Vietnamese). The platform's analytic capabilities could also identify the most viewed resources in users' native languages caregiver to provide DHS with greater insight into the needs and disparities of caregivers from different cultures.
2. Capacity to store confidential caregiver assessment data, including self-assessments, and track outcomes over time. Access to this part of the platform would be more limited and be managed with the same stringent privacy procedures applied to other forms of personal information.

Developing one caregiver resource platform with this broad functionality and making it available to all AC, EW, and OAA caregivers would improve the efficiency and effectiveness of caregiver supports across programs. As DHS considers options to execute this recommendation, HMA suggests that DHS expand the current platform in OAA programs to AC and EW as an initial step to assess key functionality DHS may want to develop in other existing state platforms. This approach would allow improvements to occur sooner and provide DHS with experience in what is most used and needed across programs. This experience would enable DHS to develop a state-operated platform in the future.

Strategy One: Make a statewide resource platform available to caregivers in AC, EW and OAA programs

ACTION STEP ONE

- Make an enhanced caregiver resource platform available to all caregivers in AC, EW, and OAA programs.

ACTION STEP TWO

- Remove the requirement that caregivers engage with a caregiver consultant to access the platform.

ACTION STEP THREE

- Identify key caregiving training resources that DHS should translate into priority languages to increase caregiver education and support use among diverse, non-English-speaking communities.

Background: Statewide Measurement Strategy

Minnesota lacks a consistent strategy for measuring the outcomes or ROI of caregiver support interventions. The OAA program has used a caregiver survey for more than 20 years, and the AC and EW programs gauge satisfaction as part of their annual assessments. The focus is solely on caregiver satisfaction with overall caregiver support services, which falls short of measuring specific outcomes (e.g., reduced SNF placement,

decrease costs) those services are intended to achieve. The OAA, AC, and EW satisfaction measures also differ enough that they cannot be aggregated or compared to determine the drivers of successful caregiver engagement and support.

Washington State's program has garnered national attention largely because of its capacity to measure and analyze caregiver support outcomes through the use of universal and uniform screeners/assessments and consistent data collection processes using a single platform. Though the state's caregiver support services are distributed across several programs, the main programmatic components are similar enough to be aggregated to determine whole system outcomes on specific measures.

Given Minnesota's own celebrated history of innovating and measuring outcomes for other LTSS services, HMA recommends that DHS implement a caregiver support program measurement strategy that leverages universal screening of all informal caregivers of participants in AC, EW, and OAA programs using uniform screening/assessment tools. We also recommend that DHS create consistent processes for maintaining/uploading assessment data to a common platform, tracking data from serial caregiver assessments over time, and conducting outcome measurements and ROI analyses.

Strategy Two: Implement a Statewide Caregiver Support Measurement Strategy

ACTION STEP ONE

Expand the existing caregiver survey to collect more detailed information from more caregivers

- Expand the annual caregiver survey to include caregivers in AC and EW programs
- Translate the caregiver survey into the top two non-English languages of caregivers engaged by caregiver consultants
- Create an action plan based on the results received
- Share results and action plan broadly (e.g., with AC, EW, and OAA program administrators, Statewide MN Caregiver Coalition, MBA, and Age Friendly Council) so they can have a greater impact

ACTION STEP TWO

Develop an outcome and ROI measurement strategy for caregiver support services

- Conduct an environmental scan of all caregiver support screening/assessment instruments in use (e.g., new measures recommended in the MBA Performance Measure Development Framework and the HEARD research project) for possible inclusion in the overarching assessment strategy.
- Integrate existing caregiver measurement efforts into a single assessment protocol that is used consistently with the caregivers of participants in all three programs.
- Create an intentional caregiver support outcome measurement strategy that collates existing work and leverages program alignment efforts to measure desired outcomes.
- Determine the desired level of interaction for AC case managers and EW care coordinators to have with a caregiver resource platform. HMA recommends that AC case managers and EW care coordinators have view-only access of caregiver assessment and outcome information housed in the caregiver resource platform. DHS should provide training for AC case managers and EW care coordinators about the platform's features to help them understand how to use it effectively as they interface with caregivers.
- Develop a before and after assessment for caregiver consultants specific to CLAS standards to be built into the Caregiver Consultant training process.

Outcome Measurement Recommendations

Without uniform caregiver assessment instruments and pre- and postintervention outcome measures for the AC, EW, and OAA caregiver support services, it is difficult to determine their strengths, weaknesses, and overall value. To evaluate the performance of its caregiver support programs, HMA recommends that Minnesota use four general categories: quality, health equity, caregiver satisfaction, and cost reduction. These characteristics should be measured on the basis of process and outcome. Even if some of the Medicaid data for the outcomes only are available for EW, it will still be instructive for DHS to collect and track that information to determine the efficacy of EW's caregiver support program and, by extension, the OAA and AC programs.

FINANCIAL IMPACT ANALYSIS

HMA analyzed the fiscal impact of the recommendations described above. This analysis was based on the potential effect of each action step at transitioning members from having an unsupported caregiver (either no caregiver, a presumed caregiver, or an identified caregiver) to a supported caregiver, as well as the potential service utilization changes that might occur when a member transitions to supported status.

To determine the potential impact, HMA first reviewed the current program status to determine the level of supports provided and how they varied by program, region, and race. Our findings showed that OAA has a far more supported caregivers than either EW or AC and that OAA had provided supports to approximately two-thirds of identified caregivers. Based on a review of national figures and program expertise, OAA has a remarkably high rate of supported caregivers. It likely represents a combination of a functional program that actively supports available caregivers and an incomplete identification of caregivers assisting OAA service recipients with their needs.

The EW and AC programs had a much lower rate of supporting caregivers, with approximately 2 percent of identified caregivers in the EW program receiving supports and 3.5 percent of identified caregivers in the AC program receiving supports. This provided a foundational basis to model increases in the rate of supported caregivers in the EW and AC program based on the patterns observed in the OAA data.

HMA also considered regional and race/ethnicity differences in our financial modeling. We observed that OAA has a higher rate of supported caregivers in the metropolitan areas of the state, a lower rate in urban regions, and the lowest rate in rural locations. This finding is consistent with the concentration of available providers, as the provider network review HMA conducted demonstrated. Based on this observation, HMA projects a larger increase in supported caregivers in metro regions for the EW and AC programs and a more moderate increase in rural areas. Race/ethnicity differences were harder to identify because of the small population sizes of some racial groups. After considering all available data, HMA felt the metro population for the Asian/Pacific Islander population showed a higher level of supported caregivers. This is interpreted as a higher propensity in the group to perform caregiver services and receive available supports, so HMA modeled a higher impact for the proposed action items.

HMA also considered national data sources, such as information from the State of Washington, which showed that, after implementing a series of reforms, Washington was able to increase the percent of older adults with a supported caregiver to approximately 2 percent for relevant wavier programs. For reference, the current rate of supported caregivers in EW is 0.3 percent and is 1.1 percent in AC.

HMA modeled a series of population movements over a five-year span. The population movements consisted of populations moving from presumed and identified caregiver status to supported caregiver status. We anticipate that some individuals will move from the current no caregiver to supported caregiver status as the result of more comprehensive assessments; however, this shift likely will be minor and inconsequentially different than the cost of individuals moving from the presumed and identified statuses.

The costs associated with population movements are based on a combination of the category a member is leaving and the one they are joining. For caregiver support services, the cost associated with the joining population is used as specifically as possible, using the exact race and region cost, if available, to account for regional differences in the cost and utilization rate of services. If no costs are available for the applicable race and region, then the average cost of caregiver supports is used instead. The cost of non-supports is used from the funds of the population a person is leaving to reflect that members who are transitioning across caregiver statuses are unlikely to shift costs from the state to caregivers.

Table 21. Projected Cost of Population Transitions in EW and AC, Year One over Baseline*

*Year One over Baseline**

Region	Race/Ethnicity of EW and AC Participants	EW Caregiver Support Dollars, Year One over Baseline	AC Caregiver Support Dollars, Year One over Baseline
Metro	Native American or Alaskan Native	$3,534	$365
Metro	Asian or Pacific Islander	$175,734	$916
Metro	Black or African American	$230,038	$11,928
Metro	Hispanic	$16,944	$826
Metro	Multiracial	$926	$141
Metro	Unknown	$11,688	$25,494
Metro	White	$263,418	$72,651
Rural	Native American or Alaskan Native	$2,503	$288
Rural	Asian or Pacific Islander	$800	$49
Rural	Black or African American	$1,178	$15
Rural	Hispanic	$6,980	$77
Rural	Multiracial	$190	$38
Rural	Unknown	$1,934	$822
Rural	White	$191,627	$26,195
Urban	Native American or Alaskan Native	$845	$46
Urban	Asian or Pacific Islander	$3,440	$87
Urban	Black or African American	$7,711	$95
Urban	Hispanic	$2,158	$158
Urban	Multiracial	$151	$22
Urban	Unknown	$2,591	$1,624
Urban	White	$138,936	$34,776
Total	**Total**	**$1,063,324**	**$176,612**

*Financial impact is total funds and does not consider administrative expenses, offsets because of decreased medical/LTSS utilization, nursing home transition periods, or administrative matching funds.

Table 22. Projected Cost of Population Transitions in EW and AC, Year Five

*Year Five over Baseline**

Region	Race/Ethnicity of EW and AC Participants	EW Caregiver Support Dollars, Year Five	AC Caregiver Support Dollars, Year Five
Metro	Naive American or Alaskan Native	$6,848	$684
Metro	Asian or Pacific Islander	$427,267	$2,072
Metro	Black or African American	$517,710	$28,538
Metro	Hispanic	$32,705	$1,560
Metro	Multiracial	$1,759	$274
Metro	Unknown	$22,392	$47,619
Metro	White	$507,080	$136,099
Rural	Native American or Alaskan Native	$9,807	$928
Rural	Asian or Pacific Islander	$3,527	$102
Rural	Black or African American	$4,775	$55
Rural	Hispanic	$26,945	$232
Rural	Multiracial	$758	$91
Rural	Unknown	$7,710	$2,837
Rural	White	$807,284	$91,095
Urban	Native American or Alaskan Native	$1,950	$105
Urban	Asian or Pacific Islander	$6,880	$173
Urban	Black or African American	$15,904	$204
Urban	Hispanic	$4,982	$364
Urban	Multiracial	$347	$50
Urban	Unknown	$5,949	$3,751
Urban	White	$321,019	$79,831
Total	**Total**	**$2,733,597**	**$396,665**

*Financial impact is total funds and does not consider administrative expenses, offsets because of decreased medical/LTSS utilization, nursing home transition periods, or administrative matching funds.

Tables 21 and 22 show the cost of all population transitions expected based on the proposed action items and recommendations.

The costs and population transitions are applicable only to the EW and AC programs. Because the OAA program has such a high rate of supported caregivers, it is not anticipated to have any additional population transitions. Instead, the primary impact on OAA will be increases in utilization of services already provided to members. As the result of the lacking cost data for OAA, cost estimates are not provided; only utilization rate changes are modeled (see Table 23).

Table 23. Projected Utilization Increases in OAA Caregiver Support Services

Caregiver Tier	Urban /Rural	Service Type	Current OAA Penetration Rate 2020	Current OAA Penetration Rate 2021	Projected OAA Penetration Rate Year 1	Projected OAA Penetration Rate Year 5
Supported Caregiver	Metro	Caregiver Support Services	**16.0%**	**13.8%**	**18.0%**	**18.0%**
Supported Caregiver	Urban	Caregiver Support Services	**0.2%**	**1.3%**	**4.0%**	**9.0%**
Supported Caregiver	Rural	Caregiver Support Services	**0.2%**	**1.1%**	**3.0%**	**7.0%**

SUMMARY

Minnesota has long had a strong reputation for its many programs that serve older adults and their caregivers and its commitment to innovative HCBS approaches. Its caregiver support services are more extensive and well-developed than almost any other state's. Those services would have an even greater impact if they were better aligned and could reach more residents. The HMA's recommendations build on the Minnesota best practices already in place by identifying priority systems changes, including investments in training, coordination, and measurement-based care.

As the state and national populations continue to age, the need to support caregivers is of heightened importance for numerous reasons. Workforce shortages are creating increased pressure on communities and states to do everything possible to help caregivers look after their well-being and, therefore, continue providing care in the homes and communities where older Minnesotans prefer to remain. As workforce pressures continue and resources are limited, focused efforts to support struggling HCBS providers and reduce administrative burden are of paramount importance. Simply stated, supporting caregivers is a workforce strategy.

Alignment of the best practices across programs will simplify the system and yield consistency that also should support improved equity and access across programs. Communication, connection, and engagement with key stakeholders are essential for effecting change and for ongoing feedback to drive further refinements. By breaking down the programmatic silos among AC, EW, and OAA programs, caregiver support services and the entire MN HCBS system working with older adults will be strengthened.

IMPLEMENTATION PLAN

The recommendations HMA has made to reform the HCBS and caregiver support systems across AC, EW, and OAA programs are comprehensive and varied. The ideas are not contingent upon one another, and should the state decide not to pursue all, implementing some of the options could still lead to incremental progress. Of note, none of the changes require modifications to existing state waiver authority to move forward because they build upon best practices and service structures presently in place. The state could consider different funding avenues for some of the recommendations, which would appropriately move funding from OAA-funded activities to Medicaid should some of the OAA best practices be expanded to also support AC and EW programs.

Appendix B offers a comprehensive implementation chart that addresses many of questions DHS may need for fiscal analysis. Some key components for consideration are noted below, followed by an implementation roadmap.

Staff Impact of HMA Recommendations

Given the structure DHS and MBA use to offer AC, EW and OAA programs, the recommendations proposed in this report would largely affect the Aging and Adult Services Division and MBA staff. The Health Care Administration Special Needs Purchasing team, and DHS Provider Enrollment would be affected. AAAs, County AC staff and MCOs would also feel the effects. State SMEs and policy leads supporting lead agencies also would be needed to support implementation. DHS's success in filling positions that focus on caregiver supports is a positive sign, but an additional staff resource with a dedicated reform implementation focus would be the most effective means of implementing the recommendations. This position could be time-limited, potentially funded with any existing ARPA funds, and start work as soon as possible. One challenge this project identified was the matrixed systems that support and guide the three programs in scope. An implementation staff resource should be conversant in these three distinct systems to effectively implement changes.

Regulatory/Compliance Impacts

As previously noted, no new Medicaid authority is necessary to move forward with proposed changes. MN DHS may want to consider Medicaid as the funding source for some activities

that OAA currently finances should the state expand those activities to support AC and EW. Legislative approval is likely needed for some of the recommendations because of funding impacts/needs and may require federal approval depending on how DHS chooses to proceed. DHS should further explore use of ARPA funds to support some of the administrative expenses, including the possibility of hiring a time-limited staffing resource to implement the system reforms. Beyond this, the primary regulatory and compliance impacts would fall to AAA HCBS provider contracts, MCO contracts with DHS, MBA contracts with EDP and Senior Linkage Line, and policy guidance in the *Community-Based Services Manual*.

Key Considerations for Implementing Recommendations

Minnesota has many changes under way and faces ongoing regulatory requirements. Some of the key program changes include MnCHOICES activity, a new MCO administering EW and renewal of the OAA state plan that may affect AAA Planning Service Areas and the funding formula. Additional changes and considerable work are needed to support the ending of the public health emergency and maintenance of Medicaid programs. Reforms must be considered in the context of federal policy changes such as HCBS quality measures and changes that might go forward as proposed in the Medicaid Access rule.[37] Additional considerations include the changing demography of Minnesota, putting more demands on the strained HCBS workforce and informal caregivers, even more so in rural communities. As awareness of disparities in our society and healthcare system rises, so will the need for strategies that can lessen these gaps and for data that can be used to hold the HCBS delivery system accountable for pursuing equity.

Implementation Strategy

HMA recommends that DHS leverage stakeholder, system navigator, and subject matter expert engagement to inform each step of HCBS and caregiver reforms. Three key forums should guide and inform implementation. The first forum, the Statewide Caregiver Advisory Committee, already is in place and would benefit from expansion and higher visibility. This committee should be used at a macro level to share information and gather feedback to inform planning and collaboration across existing work and interested stakeholders. The other two forums—the Caregiver Collaborative Learning Series and the Caregiver Navigators Best Practices Workgroup—are operational and systems-oriented to support implementation efforts. These new, recommended forums should be leveraged to ensure successful change management.

As mentioned previously, HMA recommends that DHS consider adding a staff resource with a dedicated reform implementation focus to move the suggested changes forward. This position could be time-limited, potentially funded with any existing ARPA funds, to start work as soon as possible. The best candidate to fill this role is someone who understands the AC, EW, and OAA programs and delivery structures to ensure alignment.

HMA also recommends that an internal cross-functional steering committee guide reform activity to proactively address implementation challenges that may surface because the reform initiatives cut across programs. The DHS Advisory Committee that supported this research project has many SMEs who would be effective participants in the implementation steering committee. Additional SMEs should represent provider enrollment, the Health Care Administration Special Needs Purchasing team, county policy staff, the DHS Director of Equity, and the MinnesotaHelp.info database team.

Implementation Timeline

The proposed implementation timeline, located in Appendix C, begins July 2023. Some initiatives are time-limited, others occur during a set timeframe each year, while other work should be ongoing. The timeline assumes all recommendations will be pursued. Modifications to the proposed timeline would be needed and encouraged should DHS not pursue all recommendations, seek changes to current funding structures, or decide to build a new statewide caregiver support platform.

FUTURE AREAS FOR CONSIDERATION

Offering Caregiver Support Services Earlier in the Caregiver Journey

The MN DHS expressed interest in program modifications that would permit caregivers to access supports caregiver at a younger age than OAA programs allow (60 years old) and AC and EW programs (65 years old). This approach would help provide support services to individuals with severe chronic and debilitating diseases (e.g., diabetic complications, congestive heart failure, chronic obstructive pulmonary disease) earlier in the courses of their illness to prevent or delay significant declines in functioning and forestall institutionalization. For example, the Washington State caregiver supports model, which appeals to MN DHS, serves individuals ages 55 and older.

Implications for Minnesota

The HMA research project specifically targeted the three largest publicly funded HCBS programs to effect the most expansive changes possible. As HMA assessed programmatic opportunities to reduce the eligibility age to 55, we found the program that could best be modified to fulfill this component is the Essential Community Supports (ECS) program. ECS's service menu is similar to the EW and AC programs, including family caregiver support services. Because ECS is a state-funded program with a single managing entity (the counties), modifying the program eligibility age would be easy for ECS and minimize potential risk, given the limited monthly budget allowance. HMA recommends that MN DHS explore these changes for ECS as a first step toward assessing impact and outcomes that inform larger-scale program changes in caregiver supports.

Implementation of a CLAS standards assessment specific to AC, EW, and OAA programs

The 15 national CLAS standards in Appendix F are valid measures for benchmarking performance and assessing the degree to which structures, policies, and practices respond to diverse health beliefs, practices, and needs across diverse populations. In evaluating or reevaluating compliance with each of the standards—from program leadership to workforce to community engagement—across the AC, EW, and OAA programs, DHS can obtain real-time insights into opportunities to forge or strengthen relationships with culturally and linguistically diverse caregivers. Building on the experiences of other states, undertaking an assessment is also an opportunity for MH DHS to evaluate all public-facing materials germane to the AC, EW, and OAA programs.

Implications for Minnesota

Such an evaluation could provide insights into uptake of programming among racially, ethnically, and linguistically diverse populations by geographic region, which could be compared with service utilization to gain insights into the correlation between CLAS standard-informed practices among caregiver consultants and AC, EW and OAA participants' outcomes. This analysis is important for Minnesota as it seeks to align with the CLAS standards across program staff and to ensure and maintain a standard of high-quality, person-centered services and supports for all Minnesotans.

Caregiver Public Awareness Campaigns

In the past few decades, MN and other states have increased the number and variety of caregiver support services they offer through Medicaid and other funding streams. Now many states that have completed or are developing multisector plans for aging are more heavily scrutinizing their caregiver support programs to answer the following questions:

- How do we ensure that the caregiver support services we offer are meeting the needs of our family caregivers, especially people from diverse communities?
- How do we maximize the use of those services to ensure that caregivers have optimal support?
- How do we ensure that those services address the key caregiving variables affecting participants' abilities to age in place and their total costs of care?

To answer the first two questions, more than a dozen states have conducted or are conducting caregiver public awareness campaigns, caregiver surveys, and data analyses. Their initial results broadly suggest the limitations of and need for improvements of state-level caregiver support delivery systems. One conclusion is that caregiver support services

are often underused because of a lack of caregiver awareness and engagement or the available services are misdirected.

For example, the Caregiving in Nevada 2022 Report estimated only 0.7−1.4 percent of the total estimated number of caregivers in the state receive caregiver support services. The Nevada State Plan for the Support of Family Caregivers, January 2022−December 2024, that the Nevada Lifespan Care Coalition created, attributed this low figure to inadequate marketing targeted to those caregivers and the state's dependence on caregiver self-identification to initiate services. The state plan suggested "language used in outreach efforts do not 'speak' to informal caregivers and may completely miss caregivers in communities of color." It also recommended that "caregivers need to be found/identified through public-private partnerships, and at logical points such as hospital discharge planning, where long-term care responsibilities are placed on caregivers."

The December 1, 2020, Needs Assessment of Vermonters 60+ and Their Family Caregivers that the Vermont Department of Disabilities, Aging, and Independent Living conducted found mismatches between primary services offered and caregiver needs and patterns of use. Only one-quarter of caregivers used respite services and only 16 percent found caregiver support groups helpful. More than half of the caregivers said their highest priorities were greater access to information/education regarding medical benefits, long-term care and estate planning, self-care, and medical conditions.

Implications for Minnesota

In 2013, when Minnesota's Amherst H. Wilder Foundation led a well-crafted caregiver awareness and support campaign (partly funded by DHS), the proportion of Minnesotans ages 65 and older was 13.3 percent. Ten years later, that percentage is 17 percent, suggesting that at least 100,000 more residents have technically become older adults and presumably more Minnesota family caregivers are caring for them. Because of the larger number of Minnesotans affected by caregiving today, a new MN caregiver awareness campaign would have greater salience than in 2013 and could draw more caregivers to the state's caregiver support services.

A Minnesota caregiver awareness campaign could take various forms, including state-created and -sponsored TV and radio spots, newspaper advertisements and op-eds, and social media posts. Many states also are conducting or have conducted widescale resident or caregiver surveys to calculate the approximate size of their caregiver populations; learn their needs and preferences, including those of culturally diverse caregivers; and determine the percentage of caregivers who use caregiver support services and their utilization patterns. In Minnesota, a caregiver survey could help raise the public profiles of caregiving, family caregivers, and caregiver support services, as well as inform and improve the state's caregiver support programs.

Leveraging Living Well at Home Grants to Inform Program Improvements

SMEs indicated that MN DHS values its Living Well at Home Grant program. Key attributes that have made this program successful include providing seed money for new HCBS providers to enter the public sector and paying for provider enrollment expenses. In exchange, grantees are required to enroll as providers in Medicaid programs. Unfortunately, lack of data in a usable format impeded HMA's ability to analyze how many grantees are part of the AC/EW active provider list to assess the impact this requirement has had on HCBS provider capacity.

Implications for Minnesota

The state is fortunate to have this type of grant to support HCBS provider growth and fund innovation. These efforts could be further leveraged to inventory grantee work and names in a format that does not require manual data extraction so it could be used for research and analysis. Because grantees are required to use the Enterprise Grants Management System, additional data components could be requested to assess outcomes and population impact to inform larger-scale innovation in Minnesota.

Supporting Self-Identification of Caregivers

To increase awareness of and outreach to family caregivers, the Administration for Community Living's (ACL) 2022 National Strategy to Support Family Caregivers recommends that healthcare and social service systems ensure that all intake forms adopt inclusive language to encourage self-identification among family caregivers. For example, intake forms could include a field for the name of the designated family caregiver, which could serve as a reminder to family members (and providers) that the assistance they are providing is a form of "family caregiving."

This recommendation is consistent with the CARE Act—passed by 45 states, including MN in 2015—which requires that: 1) the name of the family caregiver is recorded when an individual is admitted to the hospital, 2) the caregiver is notified when the individual is being discharged or transferred to another facility, and 3) the facility provide instruction for medical tasks the caregiver will perform once the individual returns home. The ACL recommendation and CARE Act provision suggests an available database of identified family caregivers who have relatives who were hospitalized or received social services.

Implications for Minnesota

DHS could expand its outreach to caregivers by providing written information about the state's caregiver support services to intake and discharge workers at healthcare and social service facilities to distribute to caregivers when they are being identified and trained. The department also could ask healthcare and social service facilities to seek permission from

caregivers to provide their names to DHS to receive email or postal mail with information about the state's caregiver support services.

Organize and Strengthen Caregiver Advocacy and Stakeholder Groups

More Minnesota entities, stakeholders, and advocates have focused on the needs and value of caregivers in Minnesota in recent years. There is a great opportunity now to coordinate their respective efforts through coalitions with identified leadership and intentional strategies for increasing public awareness of caregivers and caregiver support services. Potential interested parties include lead agency representatives, the Age Friendly Council, the MBA, and the AGEnda Coalition.

Implications for Minnesota:

It is an exciting time to highlight the Minnesota Caregiver Coalition. It is likely more interested participants today, if recruited, would join in its efforts. Minnesotans already have accomplished much in terms of caregiver support and awareness. The impacts could be greatly amplified through increased collaboration, organization, and strategy.

Engaging Medicaid-Enrolled, Dormant HCBS Network Providers

HMA's HCBS network analysis identified many more HCBS enrolled providers by service type than active providers of those services. For example, one percent of caregiver training and education providers, two percent of respite providers, and three percent of all PCA and companion providers are actively providing services, according to 2022 data. Any number of reasons could explain this situation, ranging from pandemic impacts, enrollment length, provider behavior of just enrolling for any services they qualify for but don't necessarily plan to offer, etc. As the workforce continues to constrict, MN DHS will need to know who is actively meeting service needs and to strategically think about how to increase workforce capacity. One strategy worth consideration is an outreach initiative to engage dormant Medicaid-enrolled providers.

Implications for Minnesota

Engaging dormant providers is one strategy MN DHS could pursue as it leverages Medicaid participating providers. The benefits of this approach include quicker engagement to start providing services, familiarity with processes and decreased DHS provider enrollment administrative burden. DHS could leverage existing communication channels that are most productive with HCBS providers to conduct outreach requesting that the provider start offering whichever service is being targeted and which they already are enrolled to provide.

DHS might also offer an incentive to providers to offer the service they are enrolled to provide but they have not filed an active claim. Cultivating this workforce would require close network monitoring to gauge true HCBS provider network capacity and may be useful

if proposed Medicaid Access regulations go forward that require closer monitoring and reporting of HCBS provider network capacity at the state level.

Formalizing Equity-Focused Statewide Networks to Standardize Community Engagement

DHS actively seeks and maintains relationships with a broad array of equity-driven stakeholders, including, but not limited to, counties, tribes, other state agencies, and consumer groups through various workgroups, initiatives, grant opportunities, and partnerships. An inclusive population health-based approach to advancing health equity and addressing the structural and social drivers of health disparities requires a statewide community engagement strategy grounded in cultural sensitivity and linguistic accessibility. Building on the Minnesota Health Equity Networks model, DHS may want to implement a regional network development pilot to explore options for standardizing an agencywide approach to community engagement to maximize administrative efficiency.

Implications for Minnesota

A streamlined stakeholder engagement strategy will allow DHS to continue its leading practice of engaging diverse stakeholders in the aging, HCBS, and caregiving spaces while fostering a culture of shared learning and inclusion for optimal policy and programmatic impact. A standardized stakeholder engagement strategy can encompass goals related to marketing/public relations, recruitment, training, retention supports, funding, sustainability, and executive or legislative champions. By tracking the pilot outcomes, DHS would be better able to ascertain its progress in engaging specific racial, ethnic, linguistic, cultural, and disability communities.

Increasing the Number of Caregiver Consultants in Minnesota

A key component of HMA's recommendations rests upon the caregiver consultant provider group. The caregiver consultants are considered one of Minnesota's best practices that ideally could be expanded to support more caregivers. The HMA recommendation is specific to expanding targeted referrals to caregivers identified in the AC and EW programs and could be expanded further to the Essential Community Supports program as well as identified enrollee caregiver in the Minnesota Senior Health Options program and Minnesota Senior Care Plus programs who are not yet eligible for EW, but have caregivers identified through MCO annual assessments. The success of these recommendations is contingent upon caregiver consultant workforce capacity.

Implications for Minnesota

It is helpful that these services can be provided remotely, but workforce cultivation will still be needed. One approach an SME interviewed for this research project suggested was

changing the certification process to remove/modify the one-day, in-person session required to serve as a caregiver consultant. Relaxing this requirement would make it easier to become a caregiver consultant and would relieve the administrative burden on AAAs, which currently host these daylong sessions. Stakeholder also told HMA that these sessions have been presented virtually, which seems like a good opportunity to expand their reach. If the state led the trainings and focused them largely on Medicaid members, the state would bear the administrative cost, thereby lessening the burden AAAs.

A different strategy would be to reach out to already enrolled HCBS providers that commonly offer other HCBS services as well as caregiver supports and incentivize workforce cultivation. HMA HCBS provider network analysis showed which other HCBS provider groups overlapped most, which could be used to targeted outreach.

Lastly, DHS could also leverage granting activity (dementia grants, GEARs granting, and Live Well at Home grants) to intentionally target caregiver consultant workforce cultivations.

Involving Volunteers and Peers for Caregiver Engagement and Support

The Administration for Community Living's 2022 National Strategy to Support Family Caregivers cites trained volunteers as an increasingly important resource for caregivers. The report states, "Volunteers have long been a mainstay of the systems that provide respite, meal delivery, transportation, and social interaction and are relatively cost effective for both programs and families. Expanding volunteer opportunities can both increase the availability of direct supports for family caregivers and create a path for expanding the direct care workforce." [38]

It also mentions the Community Care Corps, a national program for funding innovative volunteer programs around the country to support caregivers with non-medical tasks and companionship. Some LTSS providers also use CHWs and peer support specialists to play a similar role in outreach to caregivers, engaging them in available caregiver support services, and maintaining supportive relationships with them.

Implications for Minnesota

The MN DHS website describes volunteer opportunities in its Forensic Mental Health Program but no positions in LTSS. The state also certifies CHWs and peer support specialists, but no information is available about their possible roles in assisting caregivers. Designating Minnesota volunteers, CHWs and/or peers to work specifically with caregivers could assist caregiver consultants with providing outreach, guidance, and support, especially to caregivers from difficult-to-engage, diverse communities. These volunteers, CHWs, and peers would need training, oversight, and coordination guidance from the AAAs or another entity. It is likely that at least some of them were formerly caregivers who are

interested in using what they learned from their personal experiences to help other members of the community who going through similar situations.

DATA USED FOR THE PROJECT

Data Limitations

The datasets provided for the analysis of caregiver supports presented multiple limitations that limited the scope of analyses possible under this project. Some of these limitations are inherent to the nature of the dataset or the scope of the project. The DHS team worked extensively with HMA to identify and correct many flaws in the data during the course of this project. Data flaws cleaned by the DHS team are omitted from this section. We are grateful for DHS's support and work to ensure the cleanest possible data could be used in this project.

Data System Links

It is impossible to link members across OAA and MA datasets. The programs use unique identification systems that prevent tracking a member across both data sets. Standard identifiers, such as Social Security Numbers, are either not collected or cannot be shared. Adding the ability to track individuals across the two programs would help with durational analyses of the cost and acuity of individuals as their level of need and income changes with age. It would also help identify any members who churn between the two programs, allowing for more consistent care management.

Assessment Data Volatility

The assessment data that determines a member's basic information and the presence or absence of a potential caregiver is inconsistent and sometimes incomplete. In a number of instances, fields are inconsistent or switch from time to time. In addition, some fields are incomplete and populated with blank or null values. This challenge was particularly common in the OAA dataset and led to uncertainty about the prevalence of informal caregivers because of the inability to determine how many members might be married and/or living with another person. More thorough completion of the assessment data would help improve the accuracy of conclusions drawn from the data.

Care Receiver Data Challenges

The OAA data contain an identified caregiver for the care receiver when applicable. However, these data contain some inconsistencies. For example, caregiver identifiers are frequently duplicated, generally falling in three categories:

- Race/ethnicity: We observed instances of the same caregiver and recipient

combination appearing with different race values. A common example was

people identified as “White” once and another time as “White not Hispanic.”

- Multiple caregivers: Occasionally the demographics of a single ID would indicate that it potentially covered two distinct caregivers, such as a hypothetical situation of the same caregiver ID being assigned to a son age 58 and a daughter age 64, both taking care of the same 86-year-old female).
- Aging: The assessment data do not seem to age caregivers and care receivers consistently. For example, a caregiver might appear three times, ages 74, 75, and 76, while the receiver is consistently 104 years old.

Eligibility Data for OAA

Given the nature of the program, OAA data do not reflect the concept of covered members or eligibility. The lack of risk exposure units limits actuarial analyses because of limited concepts of utilization rates, per-exposure costs, service penetration, and other key actuarial figures.

Medical Data

HMA did not receive medical data for the MA beneficiaries in the EW and AC waiver programs. This limited HMA’s ability to conduct any analysis of potential medical cost reductions that might be associated with increased caregiver supports.

Lack of Cost Data for OAA

OAA data do not contain detailed, service-level cost information. The only source of cost data available for OAA is the annual reports each AAA submits, which means OAA data’s primary purpose is limited to utilization and demographic information, including the portion of service users by age, gender, caregiver status, race, and other demographic variables.

OAA Demographic Data

The demographic data provided for the OAA service recipients do not have an associated time period, which prevents tracking member demographic changes over time. Particularly relevant to this study, we are unable to see the timeframes during which a member did or did not have an identified caregiver. Consequently, our caregiver identification is logic limited to a point-in-time analysis because we cannot detect when a person might change from living alone to living with someone or having an identified caregiver to no longer having one.

Provider Data

Considerable data limitations hindered a thorough analysis of OAA providers, enrolled, and active EW/AC providers. A dataset containing NPI information for enrolled EW/AC providers was linked to a different dataset containing NPI information for active EW/AC providers.

A simpler table of provider names was provided for the list of active OAA providers; for example, these data might include “Volunteer Services of Carlton County“ and a simple list of services that the provider has delivered. Names in the OAA set were manually linked to the names seen on the EW/AC sets, which may introduce errors.

To the extent that NPI changes between the enrolled and active provider sets or providers appear only on one set or the other would result in further counting errors. In the active provider set underlying this analysis, 53 percent of the active providers also appear on the enrolled set. An updated enrolled provider set was sent to HMA; however, it was determined to exclude it from this analysis for the following reasons.

Institutional Data

HMA received no institutional data, therefore, a durational analysis that could look at the relationship between the presence of a caregiver and a supported care recipient and the time until institutionalization was not conducted.

ADL Deficits and Other Acuity Indicators

The assessment and demographic data did not contain information on ADL deficits or other variables that are relevant to the acuity of an aging population. This shortcoming limits the ability to separate utilization and cost differences driven by acuity from those driven by region, race, caregiver presence, and other variables pertinent to this analysis.

Provider Network Counts

Counts of contracted providers are done based on NPI. To the extent those change or are different between active and enrolled sets, the counts will be unreliable. Furthermore, some active providers are not listed on the enrolled set, which makes sense conceptually but could be the result of NPI changes.

Age on MA Claims

Age was not provided in the demographic/eligibility data for the MA population. HMA worked around this obstacle by deriving member age from the claims data, which included an age as of the date of service. This process is imperfect because individuals do not use services every month; thus, we are unable to determine the birth month of each individual.

The EW and AC members are high utilization populations, so this concern is minimized in this context, but data inaccuracy is possible because of due to the lack of member ages in the eligibility data.

Informal Caregiver Status

The caregiver identification information for MA data was accessed separately from the main data extract. As a result, the status information had a different cadence than assessment dates. Incorporating these data in the broader MA eligibility data required HMA to perform a series of merges, matching on exact dates when possible and close but inexact dates in other instances.

CONCLUSION

Minnesota has long had a strong reputation for its many programs that serve older adults and their caregivers and its commitment to innovative HCBS approaches. Its caregiver support services are more extensive and well-developed than almost any other state's. Those services would have an even greater impact if they were better aligned and could reach more residents. The HMA's recommendations build on the best practices already in place by identifying necessary systems changes, including investments in training, coordination, and measurement-based care.

As the state and national populations continue to age, the need to support caregivers is of heightened importance for many reasons. Workforce shortages are creating increased pressure for communities and states to do everything they can to help caregivers take care of themselves and, therefore, be able to continue providing care in the homes and communities where older Minnesotan prefer to remain. As workforce pressures continue and resources are limited, focused efforts to support struggling HCBS providers and reduce administrative burden are of greater relevance. Simply stated, supporting caregivers is a workforce strategy.

Alignment of the best practices across programs will simplify the system and yield consistency that should also support improved equity and access across programs. Communication, connection, and engagement with key stakeholders are essential for changes to be implemented effectively and for ongoing feedback to drive further refinements. By breaking down the programmatic silos among AC, EW, and OAA programs, caregiver support services and the entire MN HCBS system working with older adults will be strengthened.

APPENDIX A

HMA Project Recommendation Inventory

RECOMMENDATION ONE: HCBS Network Navigation and Service Alignment
Strategy One: Improve HCBS Network Navigation
ACTION STEP 1: Improve consistency and/or availability of network information i. Work toward improved alignment ii. Clearly document nuances and strengths iii. Prioritize key data elements to populate
ACTION STEP 2: Require MCOs to offer additional HCBS network provider training tools and resources
ACTION STEP 3: Train AAA EDP staff to be able to support AC/EW and OAA HCBS providers
Strategy Two: Alignment of Caregiver Terms, Services, and Resources
ACTION STEP 1: Align caregiver terminology and increase awareness of service consistency
ACTION STEP 2: Develop a universal referral form for caregiver support services providers
ACTION STEP 3: Implement caregiver navigator forums i. Implement a DHS-sponsored Caregiver Collaborative Learning Series ii. Implement a Caregiver Navigators Best Practices Workgroup that includes AC, EW, and OAA caregiver support-related representatives and the caregiver consultant workforce
ACTION STEP 4: Make caregiver education and support platforms available across programs without restrictions

RECOMMENDATION TWO: Enhanced Caregiver Support through Strengthened Identification of Needs and Caregiver Support Planning
Strategy One: Increase referrals to caregiver consultants across AC, EW, and OAA programs
ACTION STEP 1: Requiring AC case managers and EW care coordinators to refer identified caregivers to a caregiver consultant, with permission from the older adult or caregiver.
ACTION STEP 2: Revisit/refresh AAA caregiver touchpoints to make referrals to caregiver consultants
Strategy Two: Identified caregivers across AC, EW, and OAA programs will have individualized attention and focus
ACTION STEP 1: Leverage the evidence-based caregiver consultant assessment tool and support planning across AC, EW, and OAA programs
Strategy Three: Supporting deeper expertise to focus on caregiver needs
ACTION STEP 1: Environmental scan
ACTION STEP 2: Develop model training curriculum for caregiver consultants, including training on the national CLAS standards
ACTION STEP 3: Develop model training curriculum for AC case managers and EW care coordinators, including training
ACTION STEP 4: Orientation and annual trainings
ACTION STEP 5: Create caregiver consultant office hours to field case questions

RECOMMENDATION THREE: Statewide Caregiver Resource Platform and Measurement Strategy

Strategy One: Make a statewide resource platform available to caregivers in AC, EW, and OAA programs

ACTION STEP 1: Make caregiver education and support platforms available to AC and EW caregivers

ACTION STEP 2: Remove restrictions that OAA caregivers have to access the platform

ACTION STEP 3: Identify key caregiver training resources MN would like to have translated into priority languages

Strategy Two: Implement a Statewide Caregiver Support Measurement Strategy

ACTION STEP 1: Build out the existing caregiver survey initiative to improve impact

i. Expand to include AC and EW caregivers
ii. Translate survey into top two non-English languages
iii. Create an action plan based on survey results
iv. Share survey results and action plan more broadly to further impact and awareness

ACTION STEP 2: Develop an outcome and ROI measurement strategy for caregiver support services

i. Complete environmental scan to be able to incorporate any other caregiver support measurement in place
ii. Integrate existing caregiver measurement efforts into a single assessment protocol that is used consistently with the caregivers of participants in all three programs
iii. Create an intentional caregiver support outcome measurement strategy that collates existing work underway and leverages program alignment efforts to measure desired outcomes
iv. Determine the desired level of interaction for AC case managers and EW care coordinators to have with a caregiver resource platform
v. Develop a before and after assessment for caregiver consultants specific to CLAS standards to be built into the caregiver consultant training processes.

APPENDIX B

Comprehensive Implementation Consideration Chart

Solutions & Action Steps	Who would support this work?	Who is affected by this work?*	Regulatory/ Compliance Impact	Timeline Considerations	Planning Considerations	Solution Theme	Is this a new activity, or does it expand of current activity?
Work toward improved alignment of DHS HCBS Provider and MinnesotaHelp.	DHS provider enrollment and MinnesotaHelp database management team; DHS/MBA	AAAs, AC, EW programs and other system navigators.	MBA subcontract and potentially Medicaid network requirements and MCO contracts.	Other systems work, Medicaid Access Rule changes.	A change in focus of the MinnesotaHelp database management team would be best informed through a collaborative stakeholder process. Some of this work may be beneficial to the state to comply/perform under future changes (as currently proposed) in the Medicaid Access Rule.	Network, navigation, equity; increase access/referrals, reduction in HCBS provider administrative burden.	Expands and enhances network coordination work under way
Clearly document and make publicly available the nuances and strengths of DHS HCBS provider network and MinnesotaHelp	DHS Aging & Adult Services Division (A&ASD), provider enrollment, MBA/MinnesotaHelp database management team.	AAAs, AC, EW programs and other system navigators.	MBA subcontract and potentially MCO contracts	Work under way to modify MinnesotaHelp systems and processes.	This is a plan B solution if improving data across sources prove infeasible.	Network, navigation, communication; increase access/referrals, reduce HCBS provider administrative burden.	Expands and enhances network coordination work under way.

Prioritize key data elements to populate in both DHS HCBS provider network resources and MinnesotaHelp.	DHS provider enrollment and MinnesotaHelp database management team; DHS/MBA.	AAA, AC, EW; DHS provider enrollment, A&ASD and MBA.	MBA subcontract and potentially MCO contracts.	Work under way to modify MinnesotaHelp systems and processes.	A change in focus of the MinnesotaHelp Database Management team would be best informed through a collaborative stakeholder process.	Equity, network, navigation, communication, , reduction in HCBS provider administrative burden.	Expands and enhances network work under way.
MCOs to support EW HCBS network with additional tools and resources.	MCOs, DHS SNP staff.	HCBS providers, MCOs, provider enrollment, potentially EDPs.	MCO contracts, potentially EDP annual contracts.	Contracting calendar year cycle.	MCOs have various supports and tools in place; will want to leverage best practices to build upon.	Training, network and navigation, workforce, reduction in HCBS provider administrative burden.	Work may be new.
Train MBA EDP staff to support HCBS providers across AC, EW, and OAA programs.	AAAs, EDPs, DHS SNP staff, provider enrollment, MinnesotaHelp.	HCBS providers, MCOs, counties, provider enrollment, MinnesotaHelp, EDPs.	Potentially EDP annual contracts.	EDP workplans and 5 years of procurement activities	This effort could strengthen EDPs impact in cultivating LTSS providers and produce measurable deliverables to support the ongoing need for EDPs.	Training, network and navigation, workforce, reduction in HCBS provider administrative burden.	Work may be new.
Align caregiver terminology and increase awareness of service consistency.	DHS/MBA.	County CMs, MCO CCs, AAAs, caregiver consultants and HCBS providers.	AAA HCBS provider contracts and other caregiver-related work, MCO Contracts, CBSM.	If terminology requires changes in contracts or CBSM language, it could be done gradually as updates occur.	Recommend DHS leverage various caregiver forums to work through changes collaboratively.	Alignment, increase supports/referrals.	Existing.
Implement a universal referral form for caregiver support services providers.	DHS/MBA.	County case managers, MCO care coordinators, AAAs, caregiver consultants, and HCBS providers.	MCO contracts, AAA updates to caregiver consultant agreements.	Contracting calendar year cycle.	Recommend DHS leverage various caregiver forums to work through changes collaboratively.	Alignment, increase access/referrals, reduction in HCBS provider administrative burden.	New.

Implement a DHS-sponsored caregiver collaborative learning series (stakeholder, external community facing).	DHS/MBA: DHS caregiver staff.	County case managers, MCO care coordinators, AAAs, caregiver consultants, and HCBS providers. DHS, MBA.	Optional: Requirements to participate could be included in MCO contracts and AAA operations manual.	If adding language to contracts, update when annual changes occur.	Learning series is a key forum to increase awareness and to keep key stakeholders updated on changes DHS pursues around caregiver supports.	Alignment, communications, best practices, training.	New.
Establish a caregiver navigators best practices workgroup (operational and best practices, internal lead agency and caregiver consultant-facing forum).	DHS/MBA: DHS caregiver staff.	County case managers, MCO care coordinators, AAAs, caregiver consultants and HCBS providers. DHS, MBA.	Optional: Requirements for participation could be included in MCO contracts and AAA operations manual.	If adding language to contracts, update when annual changes occur.	Best practices series is a key forum to connect key program navigators and provide updates/request input on changes DHS pursues around caregiver supports. This would be a good group to leverage throughout implementation.	Alignment, communications, best practices, training.	New.
Requiring AC/EW referrals to caregiver consultant.	DHS: A&ASD, SNP team.	County case managers, MCO care coordinators, caregiver consultants, AAAs who train caregiver consultants training.	MCO contracts, CBSM policies.	Best to coordinate changes with MnCHOICES work in mind. If adding language to contracts, update when annual changes occur.	Caregiver consultant education and workforce development to be done before this goes live for best results.	Alignment: operational, increase access/referrals.	New.
Revisit/refresh on AAA caregiver touchpoints to make referrals to caregiver consultants.	MBA (AAAs, SLL).	AAA/SLL and older adults/caregivers served.	Updates to AAA/SLL protocol and procedures, review referral form for any necessary updates.		Will want to stagger this work to have an impact that does not overlap with when DHS potentially changes AC/EW referral protocols to refer to caregiver consultants for all identified caregiver assessments.	Increase access/referrals.	Enhances existing work.

Leverage the evidence-based caregiver consultant assessment tool and support planning across AC, EW and OAA programs.	DHS: A&ASD, SNP Team, MBA	EW/AC impacts (new info available), caregiver consultants.	Updates to CBSM may be needed	Planning work could occur in tandem with work to change AC/EW referral protocol to caregiver consultants.	Training to AC case managers and EW care coordinators on these outputs should occur to strengthen coordination and planning.	Align operational, clinical best practices, system coordination	Expands work in OAA to AC and EW.
Environmental scan of best practices to inform potential caregiver consultant training curriculum.	DHS: Caregiver services staff, MBA, AAAs.	DHS staff, AAAs, caregiver consultants	Caregiver consultant training requirements.	Consider implementing changes for AC case managers and EW care coordinators to interface with caregiver consultants before making changes as those program SMEs may have useful input to training needs.	Recommend DHS leverage various caregiver forums to work through changes collaboratively.	Training, equity, best practices.	New.
Develop model training curriculum for caregiver consultants, including CLAS standards.	DHS: caregiver services staff and Equity Director.	Caregiver consultants and AAAs if they continue to do in-person training, HCBS providers.	Caregiver consultant training curriculum, CLAS standards information.	Existing caregiver consultant training schedules. Consider implementing changes for AC case managers and EW care coordinator to interface with caregiver consultants before making changes as those program SMEs may have useful input to training needs.	Recommend DHS leverage various caregiver forums to work through changes collaboratively. Plan this initiative in tandem with a pre- and posttest as part of the CLAS standards training to demonstrate outcomes and effectiveness of training.	Training, equity, best practices.	Enhances existing training curriculum; CLAS standard training may be new.

Develop model training curriculum for AC case managers and EW care coordinators, including CLAS standards.	DHS: Caregiver services staff and Equity Director, A&ADS and SNP team staff.	County case managers, MCO care coordinators, AAAs, caregiver consultants, and HCBS providers.	Caregiver consultant training curriculum, CLAS standards information, MCO contracts.	Contract update schedules, coordination with other AC CM and EW CC training efforts (MnCAT, CDS, etc.).	DHS may want to include this training in MnCAT materials or make available more broadly to the HCBS community through CDS.	Training, equity, best practices.	New.
Establish orientation and annual caregiver consultant trainings to enhance fidelity to best practices.	DHS: caregiver services staff, MBA: AAAs.	Caregiver consultants.	AAA Caregiver consultant contracts, caregiver services, CBSM		Recommend DHS leverage various caregiver forums to work through changes collaboratively.	Training, best practices, equity.	Expansion and new.
Create caregiver consultant office hours for case questions.	DHS: Caregiver services staff, potentially a caregiver consultant.	DHS: Caregiver services staff, AC case managers, EW care coordinators, potentially a caregiver consultant.		May be beneficial to start this when the various caregiver forums start to potentially increase attention on caregiver needs. This would be a good strategy to address heighted awareness/training needs.	Office hours could be staffed by DHS caregiver staff, or possibly a caregiver consultant providing case consult.	Training, best practices.	New.
Make caregiver education and support platforms available to AC and EW caregivers.	DHS:A&ASD, SNP team, MBA.	County case managers, MCO care coordinators, caregiver consultants and HCBS providers.	MCO contracts, CBSM.	Current contract through 2024. To minimize training needs, would want to make available after mandatory referrals to caregiver consultants are operationalized.	HMA recommends DHS expand the use of the current platform to AC and EW as soon as possible and monitor use and opportunity for solutions/improvements to inform potential longer-term plan of creating a state platform to meet this need.	Alignment, increase supports/referrals.	Expands use of existing platform in OAA to AC and EW or could be all new if MN DHS seeks to create a department-owned system.

					Leverage caregiver forums to support change.		
Remove restrictions on OAA caregiver access the platform.	DHS/MBA, caregiver consultants.	Caregiver consultants.	Update any files that document current process.		DHS could initiate this change now to assess Minnesota-specific impacts before platform is expanded to AC and EW programs.	Increase access/referrals.	New.
Identify key caregiver training resources MN would like to have translated into priority languages.	DHS/MBA, DHS Equity Director.	caregivers in AC, EW, and OAA; case managers, care coordinators, and caregiver consultants.	Update any caregiver platform marketing materials used.	Recommend this be implemented as soon as possible to start assessing impacts now, as there are no other planning contingencies (outside of funding).	May want to leverage the MBA cultural consultants to help inform this work and target materials for translation. DHS will want to gather data on current training modules most accessed to inform decisions on what to translate.	Increase access/referrals, equity.	New.
Expand the OAA existing Caregiver Survey initiative to AC and EW.	DHS: A&ASD, SNP team, and MBA.	AC case managers, EW care coordinators, caregiver consultants.		Will want to coordinate timelines with other survey, quality initiatives in place across programs to reduce confusion.	Select a timeline that does not overlap with other older adult/caregiver outreach/survey activity (ex: CAHPS, NCI). Leverage caregiver forums to provide notification of survey timelines to key contacts and encourage caregiver participation.	Alignment, measurement.	Expands OAA survey activity to AC and EW.
Translate the existing OAA caregiver survey into top two non-English languages.	DHS/MBA, DHS Equity Director			Identification of languages needs to occur early enough for translation services and translation review processes.	May want to leverage the MBA cultural consultants to help inform this work and provide feedback on survey terminology/questions.	Alignment, equity.	New.

Create an action plan based on survey results.	DHS: Caregiver services staff, MBA, SNP team.	AC, EW, OAA key program contacts, other key stakeholder groups.		Should occur soon after survey results analysis.	Action plan should align/support caregiver measurement strategy goals.	Best practices, communications.	New.
Share survey results and action plan more broadly to further impact and awareness.	DHS: Caregiver services staff.	AC, EW, OAA key program contacts, other key stakeholder groups.		Should occur soon after an action plan is created.	Key stakeholders could include MBA, MCOs, counties, Age Friendly and the Statewide MN Caregiver Coalition.	Best practices, communications.	Expands current process of sharing survey results.
Environmental scan to incorporate any other caregiver support measurement in place.	DHS: Caregiver services staff/MBA, SNP team.	DHS staff, AAAs, caregiver consultants, MCOs, other state caregiver stakeholders.		Will want to identify other survey/measure-ment activity in place and when initiative occurs and when results available to align planning.	Environmental scan should, at minimum, incorporate activities in place across AC, EW, and OAA programs.	Measurement, best practices.	Expands and targets efforts DHS has previously pursued.
Integrate existing caregiver measurement efforts into a single assessment protocol that is used consistently with the caregivers of participants in all three programs.	DHS/MBA	Caregiver consultants, DHS/MBA for measurement use.	Caregiver consultant contracts with AAAS; CBSM.	This work would occur after caregiver consultants are effectively supporting caregivers across all three programs.	Alignment of the assessment tool will support DHS's ability to implement a strong measurement strategy.	Measurement, best practices, alignment.	New.

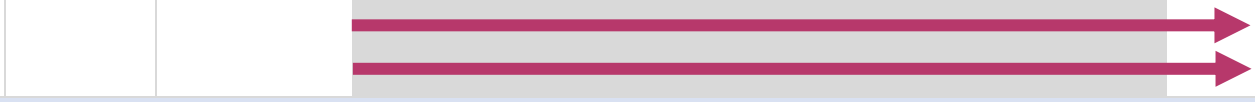
Create an intentional caregiver support outcome measurement strategy that collates existing work underway and leverages program alignment efforts to measure desired outcomes.	DHS: Caregiver services staff.	Caregiver consultants, DHS/MBA for measurement use.	MCO contracts, caregiver consultant contracts with AAAs; CBSM.	Will want to identify other survey/measure-ment activity in place, when initiative begins, and when results are available to align planning.	The overarching strategy should encompass various measurement activities such as assessment data, engagement rates, survey responses, CLAS standards training results, and others that the state identifies. ROI analysis could be assessed in EW program where medical claims are accessible to DHS.	Measurement, best practices, alignment.	New.
Determine the desired level of interaction for AC case managers and EW care coordinators to have with a caregiver resource platform.	DHS: A&ADS, SNP team	AC CMs, EW CCs, caregiver consultants.	MCO contracts, caregiver consultant contracts with AAAS; CBSM.	To be determined before potential expansion of current platform contract.	Interaction may be limited due to other change management and capacity constraints with other implementation work occurring (MnCHOICES).	Best practices, alignment, increase access/referrals.	New.
Develop a before and after assessment for caregiver consultants specific to CLAS standards to be built into the caregiver consultant training processes.	DHS: Caregiver services staff.	Caregiver consultants, AAAs, DHS: caregiver services staff.	Caregiver consultant training curriculum.	Initiate at same time CLAS standards training component is added to assess impact.	Additional training component could be incorporated into the overall caregiver consultant training curriculum.	Measurement, best practices, equity.	New.

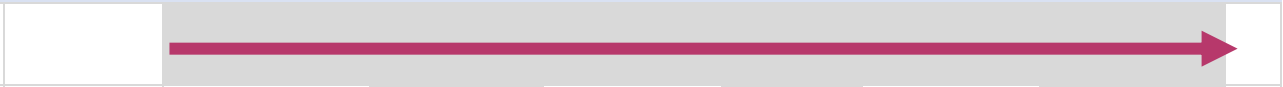
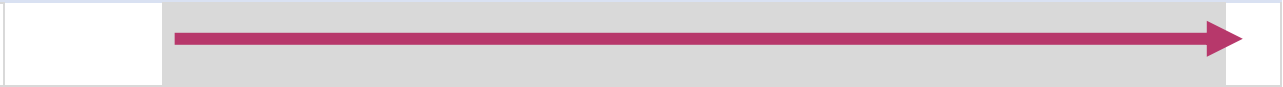
APPENDIX C

Minnesota DHS Caregiver and HCBS Project Reform Implementation Timeline

	July-23	January-24	July-24	January-25	July-25	January-26	July-26	Ongoing
HCBS Network Navigation and Service Alignment								
Strategy One: Improve HCBS network navigation								
Improve consistency and/or availability of network information		→	→	→	→	→	→	
MCOs to support EW network with tools and resources		→	→	→	→	→	→	
Train AAA EDP staff to be able to support AC/EW and OAA HCBS providers								
Strategy Two: Alignment of caregiver terms, services, and resources								
Align caregiver terminology and increase awareness of service consistency		→	→					
Develop a universal referral form for caregiver support services providers								
Implement caregiver navigator forums	→	→	→	→	→	→	→	
Make caregiver education and support platforms available across programs without restrictions		→	→	→	→	→	→	

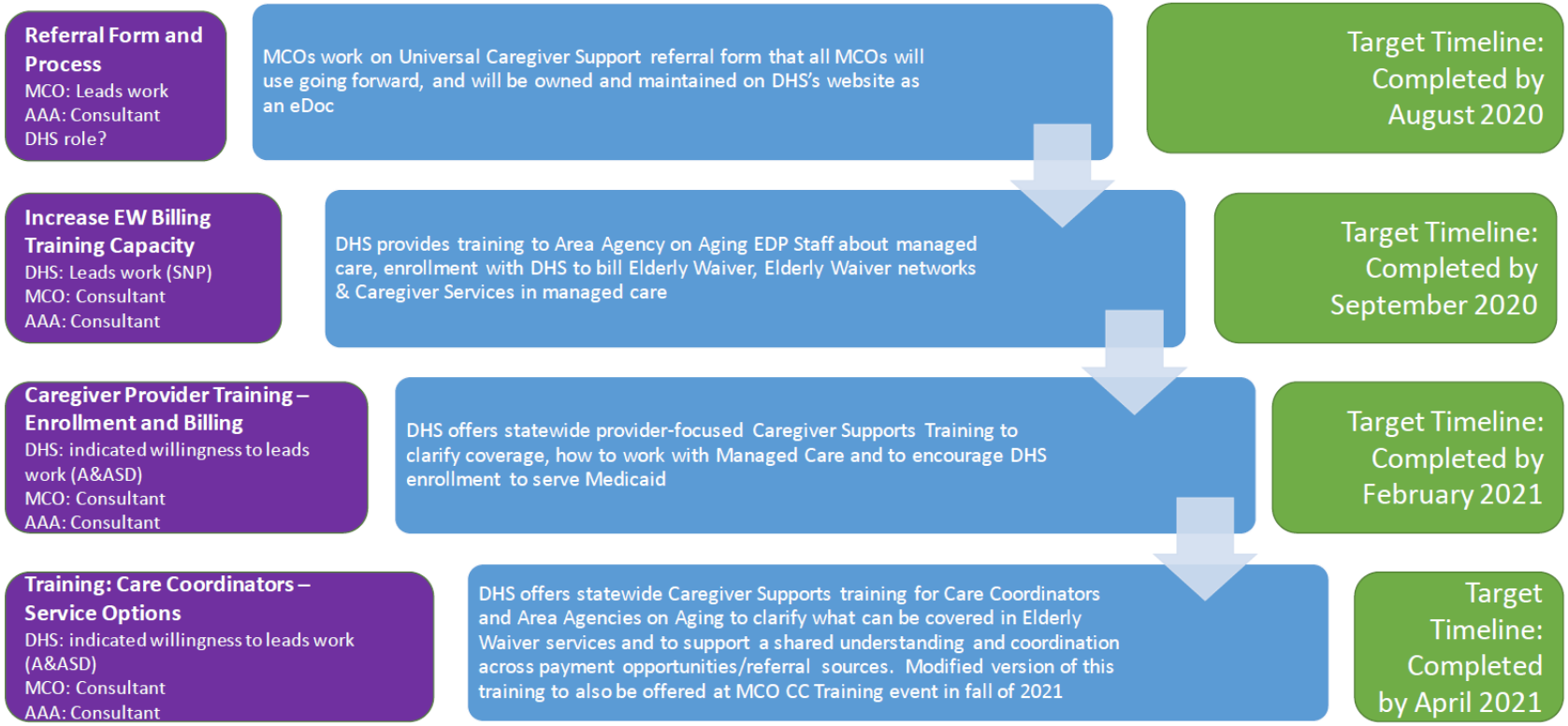
Enhanced Caregiver Supports through Strengthened Identification of Needs and Support Planning	
Strategy One: Increase referrals to caregiver consultants across AC EW and OAA	
Requiring AC/EW referrals to caregiver consultant	
Revisit/refresh AAA caregiver touchpoints to make referrals to caregiver consultants	
Strategy Two: Identified caregivers across AC, EW and OAA programs will have individualized attention and focus	
Leverage the evidence-based caregiver consultant assessment tool and support planning across AC, EW, and OAA programs	
Strategy Three: Supporting deeper expertise to focus on caregiver needs	
Environmental scan	
Develop model training curriculum for caregiver consultants, including training on the national CLAS standards	
Develop model training curriculum for AC case managers and EW care coordinators, including training	
Orientation and annual trainings	
Create caregiver consultant office hours to field case questions	



Statewide Caregiver Resource Platform and Measurement Strategy	
Strategy One: Make a statewide resource platform available to caregivers in AC, EW, and OAA programs	
Make caregiver education and support platforms available to AC and EW caregivers	
Identify key caregiver training resources MN would like to have translated into priority languages	
Strategy Two: Implement a Statewide Caregiver Support Measurement Strategy	
Build out the existing caregiver survey initiative to improve impact	
Develop an outcome and ROI measurement strategy for caregiver support services	

APPENDIX D

2020 Caregiver Supports Improvement Plan



Deliverables and Training

Problem Statement

Despite the robust caregiver support benefit set available through Title III and Elderly Waiver funds, Minnesotans and their caregivers are not receiving caregiver supports to the degree to which they are funded, and likely needed.

Surveys to Care Coordinators and Caregiver providers, review of Caregiver claims paid and community conversations about the needs and understanding of services available underscore the overdue need for attention to this service category and improvement opportunity.

Additional opportunities have been identified around the need to recruit more providers to serve Medicaid members, educate providers around this funding source (which supports provider sustainability), how to work with MCOs and educate the entire community around what work is covered with services that are currently available.

Opportunities for closer collaboration among key stakeholders have been identified, which, if pursued, would undoubtedly result in many more aging Minnesotans having their needs met more effectively and improved quality of life for all involved.

Key Solutions Partners

DHS Aging & Adults Service Division

DHS Special Needs Purchasing

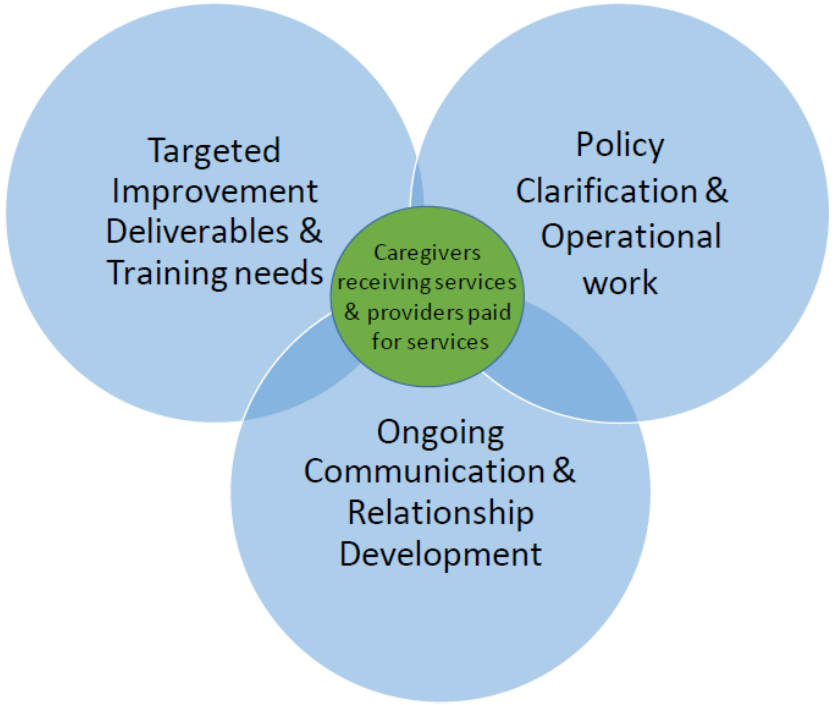
DHS Provider Enrollment

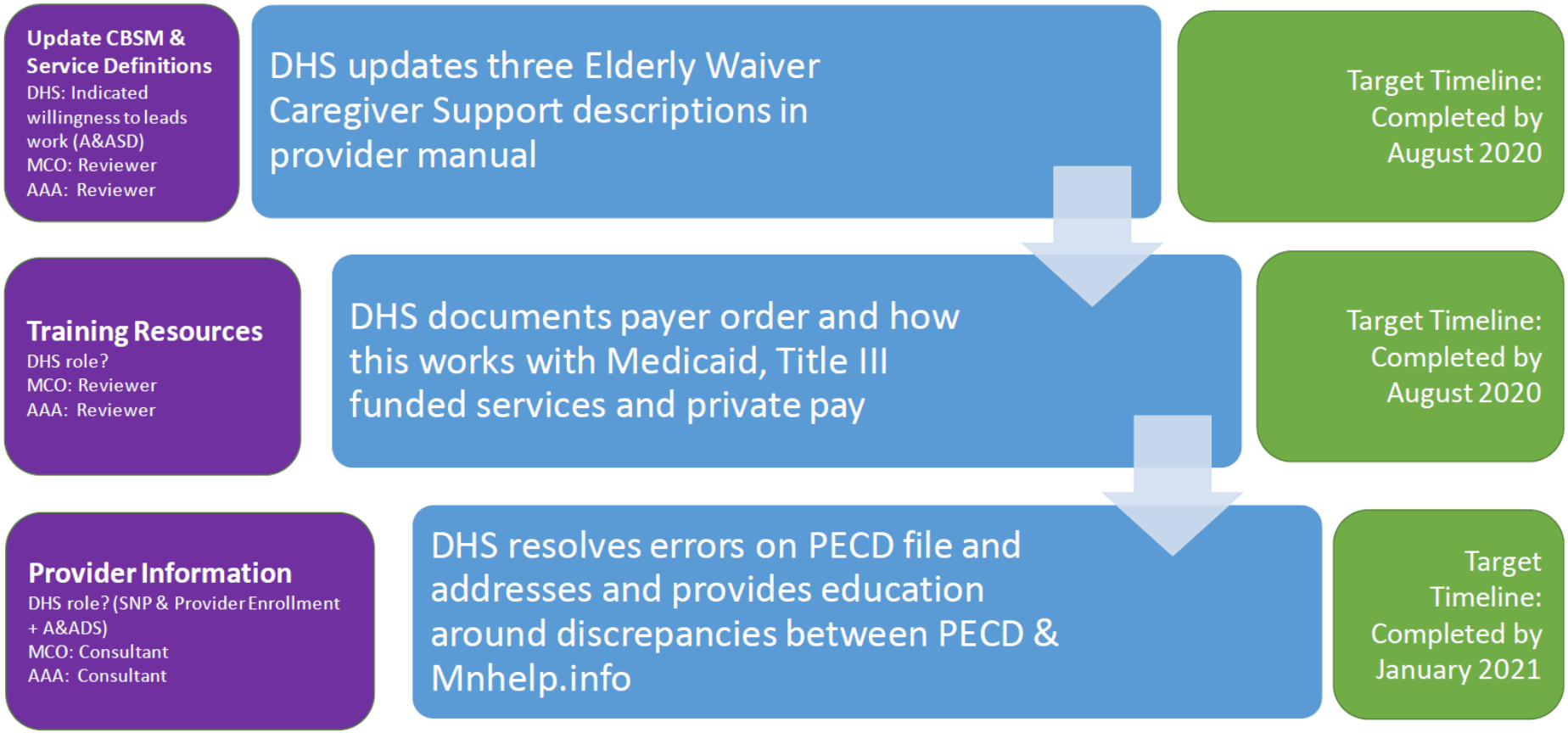
Area Agencies on Aging

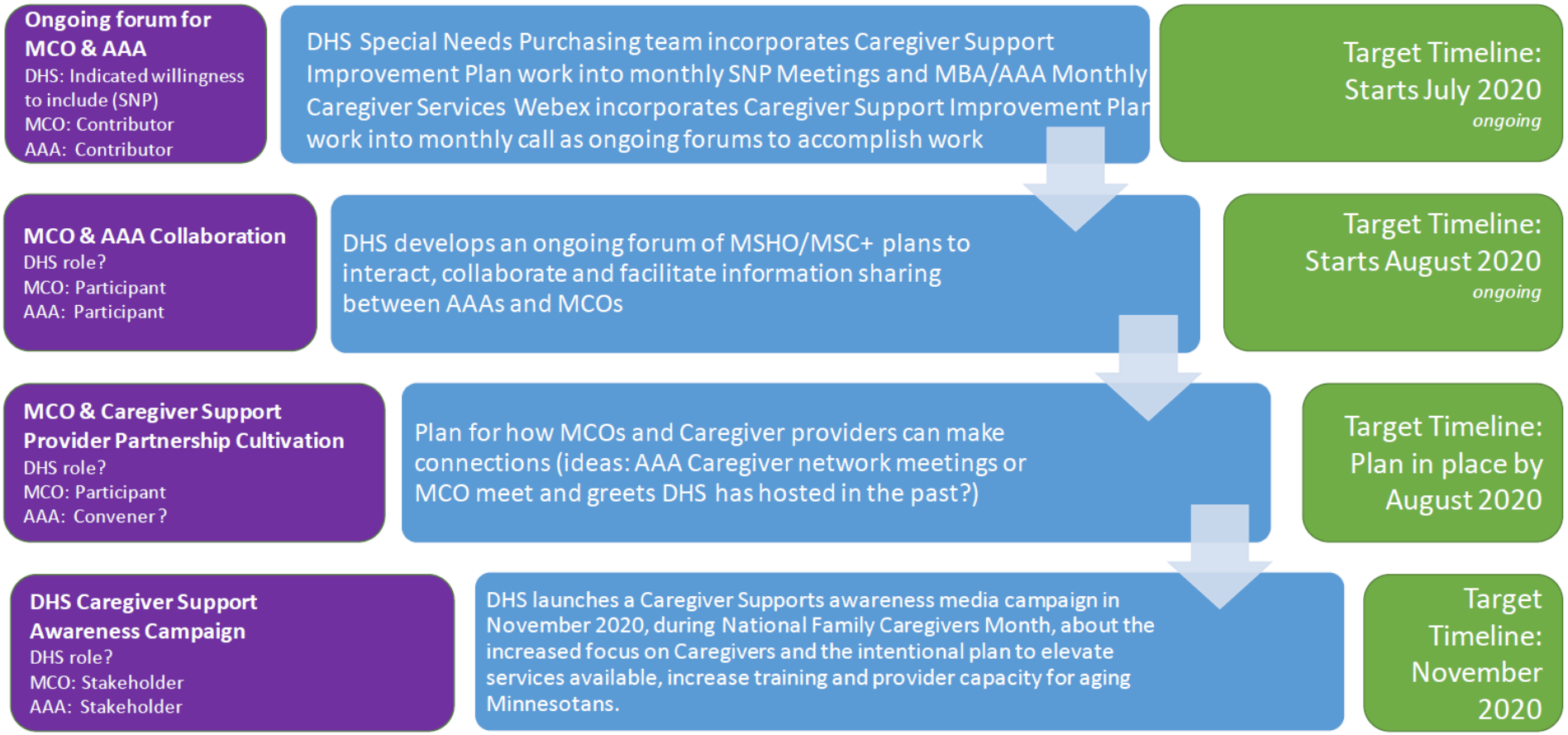
MSHO & MSC+ Managed Care Organizations

Caregiver Service Providers

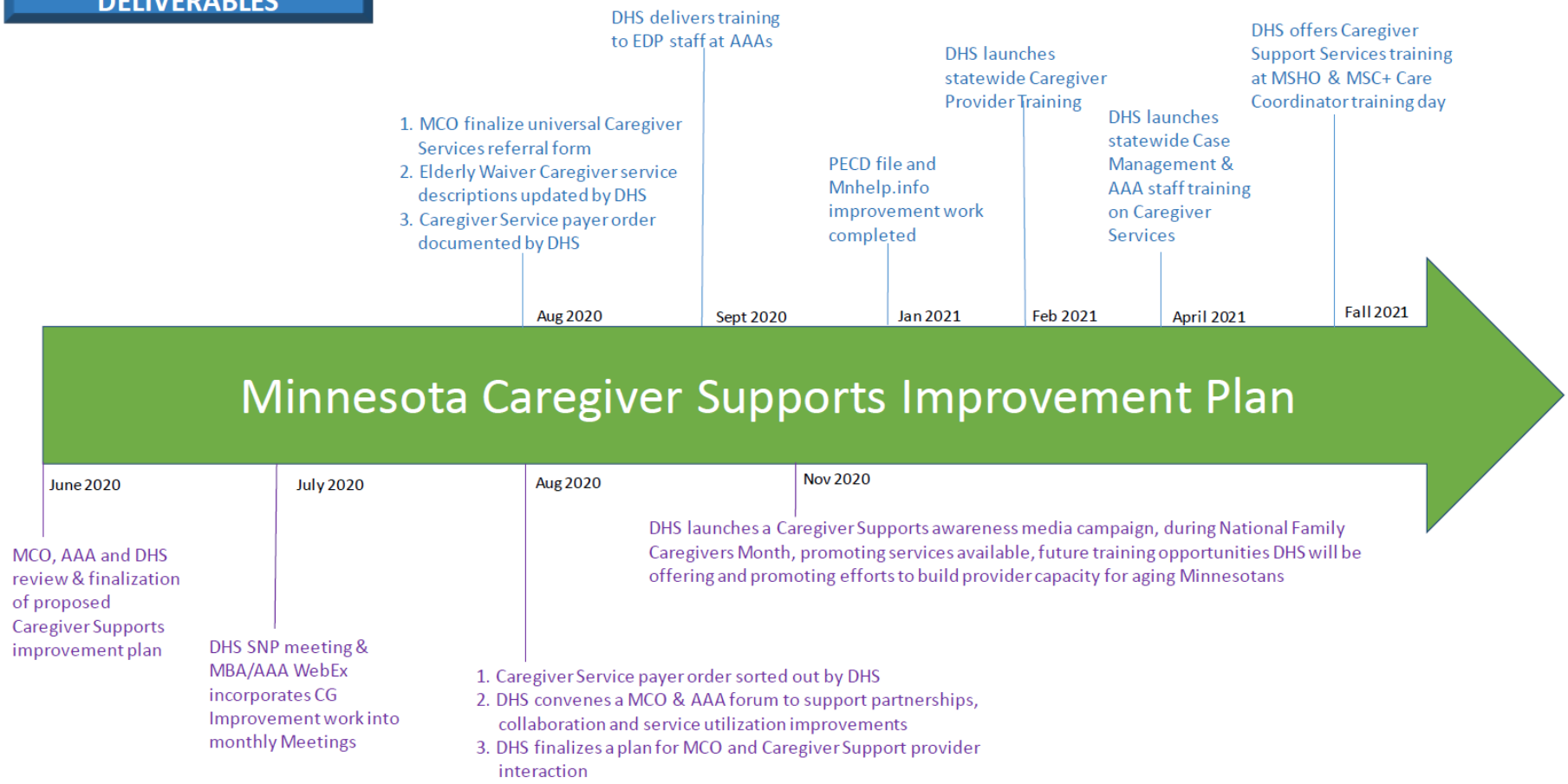
Proposed areas of work to accomplish improvements




Update CBSM & Service Definitions
DHS: Indicated willingness to leads work (A&ASD)
MCO: Reviewer
AAA: Reviewer
DHS updates three Elderly Waiver Caregiver Support descriptions in provider manual
Target Timeline: Completed by August 2020
Training Resources
DHS role?
MCO: Reviewer
AAA: Reviewer
DHS documents payer order and how this works with Medicaid, Title III funded services and private pay
Target Timeline: Completed by August 2020
Provider Information
DHS role? (SNP & Provider Enrollment + A&ADS)
MCO: Consultant
AAA: Consultant
DHS resolves errors on PECD file and addresses and provides education around discrepancies between PECD & Mnhelp.info
Target Timeline: Completed by January 2021


Ongoing forum for MCO & AAA
DHS: Indicated willingness to include (SNP)
MCO: Contributor
AAA: Contributor
DHS Special Needs Purchasing team incorporates Caregiver Support Improvement Plan work into monthly SNP Meetings and MBA/AAA Monthly Caregiver Services Webex incorporates Caregiver Support Improvement Plan work into monthly call as ongoing forums to accomplish work
Target Timeline: Starts July 2020
ongoing
MCO & AAA Collaboration
DHS role?
MCO: Participant
AAA: Participant
DHS develops an ongoing forum of MSHO/MSC+ plans to interact, collaborate and facilitate information sharing between AAAs and MCOs
Target Timeline: Starts August 2020
ongoing
MCO & Caregiver Support Provider Partnership Cultivation
DHS role?
MCO: Participant
AAA: Convener?
Plan for how MCOs and Caregiver providers can make connections (ideas: AAA Caregiver network meetings or MCO meet and greets DHS has hosted in the past?)
Target Timeline: Plan in place by August 2020
DHS Caregiver Support Awareness Campaign
DHS role?
MCO: Stakeholder
AAA: Stakeholder
DHS launches a Caregiver Supports awareness media campaign in November 2020, during National Family Caregivers Month, about the increased focus on Caregivers and the intentional plan to elevate services available, increase training and provider capacity for aging Minnesotans.
Target Timeline: November 2020

DELIVERABLES



COMMUNICATIONS

APPENDIX E

Caregiver Program Current/Future State Changes Table

The table below outlines key current and future program components based on implementation of recommendations.

Caregiver Support Component	EW/AC Current Model	EW/AC Future Model	OAA Current Model	OAA Future Model
Access to caregiver consultants	Exists through two EW/AC covered services (unbeknownst to case managers)	Continued benefit coverage in EW and AC with more awareness and expectations for outputs from these service referrals and stronger collaboration between navigation entities	Available.	Available
Referral to caregiver consultants	No requirement, no activity in place	Program requirements that AC case managers and EW care coordinators make a referral to caregiver consultants when a caregiver has been identified as part of the older adult assessment	Typically, providers engage potential caregivers in need of help, and few referrals are made from AAAs or Senior Linkage Line	In addition to providers identifying caregivers to engage, AAA and Senior Linkage Line implement Referral protocol to have caregivers they are speaking with referred for follow-up discussion
Entity completing caregiver assessment	AC case managers and EW care coordinators	Caregiver consultants (funded as AC/EW Benefit)	Caregiver consultant	No change

Caregiver assessment tools	LTCC/ MnCHOICES Caregiver Module	Caregiver consultant assessment	Each caregiver consultant may have a slightly different model	Assessment tool would have less variability
Caregiver assessment data maintenance	In case manager file/ maintained in MnCHOICES platform	Availability of caregiver education and support platform	Paper copies maintained by caregiver consultant providers	Availability of caregiver education and support platform
Caregiver resource advocacy	Provided by AC case managers and EW care coordinators	Provided by caregiver consultant, supported by a caregiver education and support platform, and done in collaboration with AC case managers and EW care coordinators	Provided by caregiver consultant, supported by a caregiver education and support platform	No change

APPENDIX F

National Culturally and Linguistically Appropriate Service Standards

According to the US Department of Health and Human Services, “The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by establishing a blueprint for health and healthcare organizations.[39]

Principal Standard

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

- Offer language assistance to individuals who have limited English proficiency or other communication needs, at no cost to them, to facilitate timely access to all healthcare and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia

materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

APPENDIX G

Caregiver Measurement Quality Focus Area

Quality

The quality of caregiver support services programs can be judged from two perspectives:

- By their effectiveness with reaching out to and engaging a greater proportion of the total population of caregivers who could benefit from services, especially people from minority, underrepresented, or high-risk groups
- By the difference they make for participant and caregiver well-being and healthcare utilization

Recommended process measures

- Caregiver intention for participant LTC placement
- Number of caregiver consultant referrals
- Number of caregiver consultant assessments completed
- Number of caregivers using a caregiver resource platform
- Number of claims paid for caregiver support services

Recommended outcome measures

- Percentages of caregivers from estimated total caregiver population engaged in caregiver support services
- Percentages of estimated minority, underrepresented, and high-risk caregivers engaged in caregiver support services
- Changes in aggregated measures of caregiver burden
- Aggregated caregiver self-reports of the impact of caregiver support services
- Number of participant ED visits per 1,000 participant months (HEDIS EDU)
- Number of participant hospital admissions per 1,000 participant months (HEDIS IHU)
- All-case participant 30-day readmission rates (HEDIS PCR)
- Average length of stay for participant hospital admissions
- Participant nursing home placement rate
- Participant mortality rates

Health Equity

Recommended process measures

- Caregiver characteristics
- Percentage of caregivers from diverse communities who receive caregiver support services and complete caregiver survey
- Number of caregivers who have accessed targeted, translated training or educational content in the caregiver resource platform
- Percentage of caregiver support providers with language capacity data available in Minnesota.Help.info network data base

Recommended outcome measures

Caregiver survey: Year-to-year percentage change of caregivers receiving caregiver support services who complete a translated caregiver satisfaction survey and identify as being representative of a diverse culture or ethnic community

Caregiver survey: Average caregiver satisfaction scores of caregivers identifying as being representative of a diverse culture/ethnicity with all aspects of caregiver support services, including outreach/promotional efforts, enrollment process, orientation, educational and training resources, referrals to healthcare and SDOH resources, counseling/coaching (if provided), and customer relations (e.g., courtesy, timeliness, follow-up, communication, cultural competence, etc.)

Caregiver Satisfaction

Some caregivers will primarily seek education. Others only will want help with identifying local resources. Others will be mostly interested in ongoing emotional support. Measuring caregiver satisfaction, therefore, will require assessing satisfaction with a range of caregiver support services.

Recommended process measure

- Percentage of caregivers receiving caregiver support services who complete caregiver survey

Recommended outcome measure:

- Year-to-year percentage change of caregivers receiving caregiver support services who complete caregiver survey
- Average caregiver satisfaction scores with all aspects of caregiver support services, including outreach/promotional efforts, enrollment process, orientation, educational and training resources, referrals to healthcare and SDOH resources, counseling/coaching (if provided), and customer relations (e.g., courtesy, timeliness, follow-up, communication, cultural competence, etc.)

Cost Reduction

This category includes measuring participants' total cost of care (under Medicaid) and comparing this figure with the cost anticipated by predictive analytics, given a participant's age, medical diagnoses, functional and cognitive status, and other circumstances.

Recommended process measures:

- Baseline data on participant average total cost of care in a designated look-back period (usually 18 months to three years) prior to caregiver engagement in caregiver support services
- Anticipated participant total cost of care based on risk scores assigned by DHS or MCO predictive analytics
- Recommended outcome measures:
- Participants' average total cost of care following use of caregiver support services
- Average difference in predicted and actual participants' total cost of care following use of caregiver support services

APPENDIX H

Washington State Caregiver Programs Compared with Minnesota HCBS Programs

The information below is based on the National Academy for State Health Policy (NASHP) WA Model information[40]:

Key Features of Program Success:

1. Emphasis on identifying caregivers in need of support before more formal LTSS are needed and connecting them with resources.
2. Robust data and outcome measurement to demonstrate success

Washington also has:

- A paid family leave program and a statewide long-term care insurance program. State policymakers have been able to demonstrate cost savings and improved quality of life. These programs proactively support caregivers of individuals likely to spend down to Medicaid LTSS. Programs were designed to model Washington's Family Caregiver Support Program, (FCSP), which: assesses caregivers and provides training, respite, and other resources.
- Robust data collected from these programs demonstrate that Washington's investments in family caregivers have ultimately contained costs while improving the well-being of caregivers and individuals receiving care.

Washington's comprehensive Medicaid 1115 waiver program has shown a return on investment since its inception in 2017. This waiver has two caregiver support programs, the WA MAC Program, and the WA TSOA Program.

Component	WA MAC Program	Similar MN Programs	WA TSOA Program	Similar MN Programs
Program name	Medicaid Alternative Care (MAC).	Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO).	Tailored Services for Older Adults (TSOA).	AC/OAA AAA programs mix.
Population	Caregiver of a Medicaid-eligible individual not using LTSS.	Caregiver of MSHO/MSC+ non-EW (community wellness) older adults.	Supports individual and caregivers are ineligible for Medicaid (or choosing no Medicaid) who will likely eventually need LTSS.	AC= Nursing facility level of care NFLOC. AAA= age-based eligibility.
Services	• Caregiver assistance with homemaker, respite, meals on wheels and minor home repairs. • Training and Education • Specialized medical equipment and supplies • Health maintenance and therapy supports, such as Adult Day Services and counseling.	Full Medicaid and waiver benefits for NFLOC people. Some available for non-waiver enrollees as supplemental benefits, + PCA	• Caregiver assistance with Homemaker, respite, MOW, and minor home repairs. • Training and Education • Specialized medical equipment and supplies • Health maintenance and therapy supports, such as ADS and counseling.	Caregiver assistance with homemaker, respite, MOW, and minor home repairs. • Training and education • Specialized medical equipment and supplies • Health maintenance and therapy supports, such as ADS and counseling

Access to services	Screened by TCARE. Budget of up to $4,362 over 6 months. More flexibility with eligibility determination than Medicaid.	Annual CC assessment of qualifying older adult and identified caregiver at minimum. More extensive assessment if referred for caregiver counseling.	Screened by TCARE. Budget of up to $4,362 over 6 months. More flexibility with eligibility determination than Medicaid.	AC: Annual CM assessment of qualifying older adult and identified caregiver at minimum. More extensive assessment if referred for caregiver counseling. AAA: Typically, provider-identified caregivers. Caregiver consultation creates service/support plan and is an extensive assessment (could be a few hours).
Age	55 and older.	65 and older.	55 and older.	AAA: Ages 60 and older. AC: Ages 65 and older.
LOC	NFLOC.	No limit.	NFLOC.	AC only NFLOC. AAA: No limit.
Measurement baseline	TCARE assessment strategy produces a range of data on caregivers and recipients of care and allows the state to establish a baseline from which to study the impact of the program.	No caregiver outcomes being measured.	TCARE assessment strategy produces a range of data on caregivers and recipients of care and allows the state to establish a baseline from which to study the impact of the program.	AC: Unaware of caregiver results being measured.

				AAA: Caregiver survey is only measurement mechanism and is more about satisfaction.
Cost savings determined	Synthetic estimate projection (heavy emphasis on Medicare and dual eligible data).	No cost savings specific to caregiver service provision being measured.	Synthetic estimate projection (heavy emphasis on Medicare and dual eligible data).	No cost savings specific to caregiver service provision being measured.
How program outcomes are measured	Washington's evaluation is largely based on data from TCARE family caregiver assessments combined with data on ED department visits, inpatient admissions, 30-day readmission rate, nursing home admission rate, and mortality rate.	No specific caregiver supports program outcomes being measured.	Washington's evaluation is largely based on data from TCARE family caregiver assessments combined with data on emergency department visits, inpatient admissions, 30-day readmission rate, nursing home admission rate, and mortality rate.	AC: No specific caregiver supports program outcomes being measured. AAA: Caregiver survey measurement mechanism in place; is primarily about satisfaction.
Financial outcomes	Though the waiver is still in progress, data from the first few years show that the program is successfully delaying Medicaid LTSS and preventing hospitalizations. Care recipients whose caregivers were screened following FCSP expansion	No cost savings specific to caregiver service provision being measured.	Though the waiver is still in progress, data from the first few years show that the program is successfully delaying Medicaid LTSS and preventing hospitalizations. Care recipients whose caregivers were screened following FCSP expansion	AC & AAA: No specific caregiver supports financial outcomes being measured.

	were 20 percent less likely to enroll in Medicaid LTSS in the year after screening, controlling for other factors.		were 20 percent less likely to enroll in Medicaid LTSS in the year after screening, controlling for other factors.	
Caregiver experience	Survey results find high levels of satisfaction among caregivers and recipients.	Assessor asks high level questions about satisfaction. Unaware of any survey activity specific to caregivers.	Survey results find high levels of satisfaction among caregivers and recipients.	AC: Assessor asks high level questions about satisfaction. Unaware of any survey activity specific to caregivers. AAA: Caregiver survey.

ENDNOTES

[1] Reinhard SC, Caldera S, Houser A, Choula RB. Valuing the Invaluable: 2023 Update Strengthening Supports for Family Caregivers. Published by AARP Public Policy Institute March 8, 2023. Available at: https://www.aarp.org/content/dam/aarp/ppi/2023/3/valuing-the-invaluable-2023-update.doi.10.26419-2Fppi.00082.006.pdf. Accessed May 29, 2023.

[2] Young HM, Bell JF, Whitney RL, Ridberg RA, Reed SC, Vitaliano PP. Social Determinants of Health: Underreported Heterogeneity in Systematic Reviews of Caregiver Interventions. *The Gerontologist*. 2020;60(Suppl 1):S14-S28. doi: 10.1093/geront/gnz148

[3] Estrada LV, Resendez J, and Perez GA. The Role of National Paid Family and Medical Leave Policies in Promoting Health Equity for Older Adults and Their Caregivers. *Journal of Gerontological Nursing*. 2022;48(3):5–10. doi: 10.3928/00989134-20220209-01

[4] Services include caregiver training and education, caregiver coaching and counseling, and caregiver consultation services. Per DHS direction, family memory care was excluded from this list due to no utilization.

[5] PCA numbers represent both state plan and extended PCA for EW and AC recipients. The DHS data group of 65+ HC (home care only) is not represented in these numbers.

[6] As defined in section O, Informal Caregiver Assessment, portion of the LTCC 3428 form that MCOs use.

[7] As defined in section O, Informal Caregiver Assessment, portion of the LTCC 3428 form MCOs use.

[8] As defined in section O, Informal Caregiver Assessment, portion of the LTCC 3428 form MCOs use.

[9] Minnesota Board on Aging. Family Caregiving. Available at: https://mn.gov/board-on-aging/connect-to-services/family-caregiving/. Accessed April 19, 2023.

[10] Refer to the 2020 Minnesota Caregiver Supports Improvement Plan in Appendix D

[11] Services include caregiver training and education, caregiver coaching and counseling, and caregiver consultation services. Per DHS direction, family memory care was excluded from this list due to no utilization.

[12] Refer to the 2020 Minnesota Caregiver Supports Improvement Plan in Appendix D

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